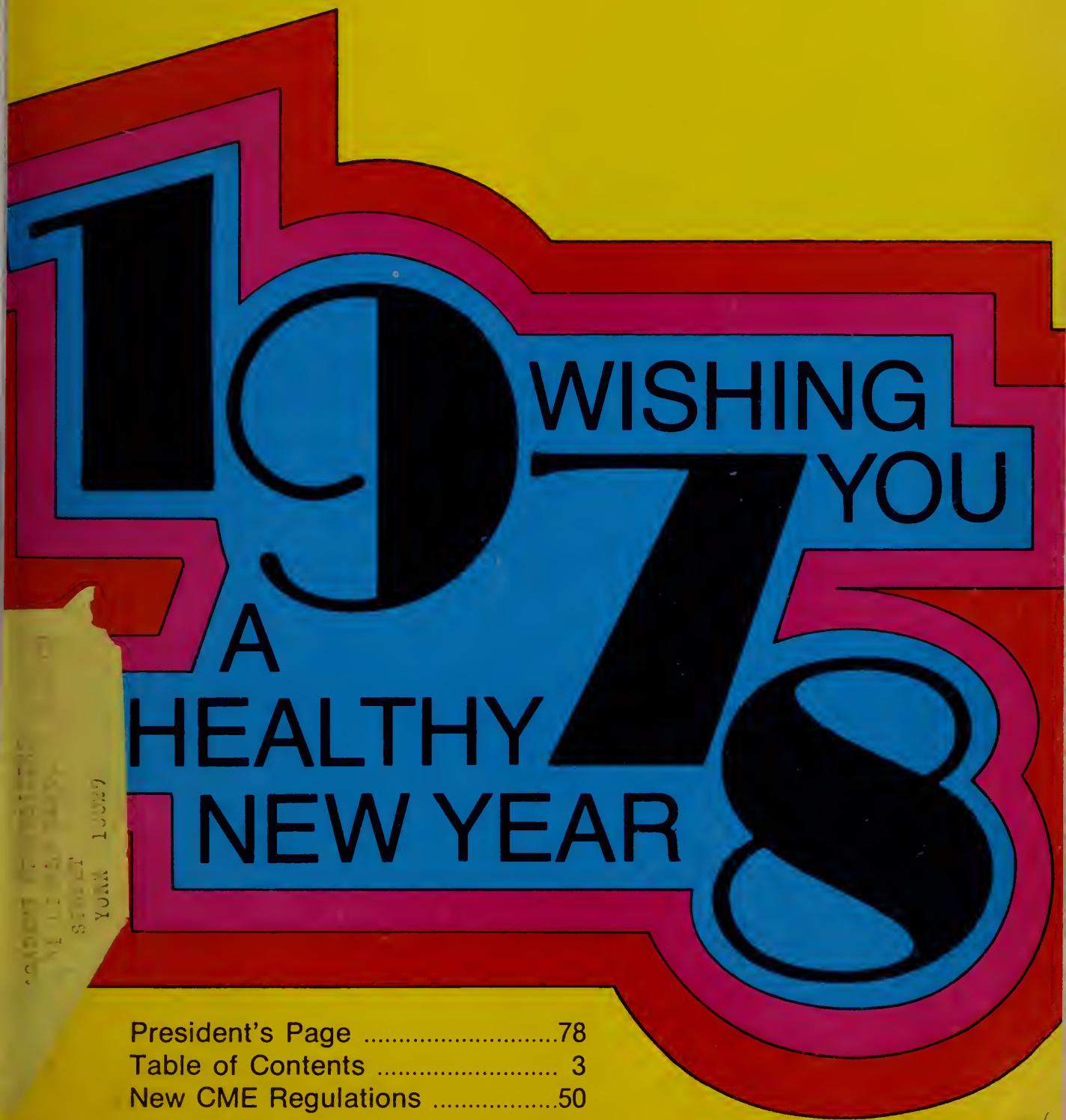
The New York
Academy of Medicine

*By Exchange*

BALCONY

# Illinois Medical Journal

OFFICIAL JOURNAL OF THE
ILLINOIS STATE MEDICAL SOCIETY
Volume 153, Number 1 - January 1978




President's Page .....78
Table of Contents ..... 3
New CME Regulations .....50

# BURROUGHS WELLCOME CO. MAKES CODEINE COMBINATION PRODUCTS.

## YOU MAKE THE CHOICE.




## EMPIRIN® COMPOUND w/ CODEINE #3

Each tablet contains:
codeine phosphate, 32 mg (gr ½),
(Warning: May be habit-forming);
aspirin, 227 mg; phenacetin, 162 mg;
and caffeine, 32 mg.

C III

## EMPRACET™ w/ CODEINE #3

Each tablet contains:
codeine phosphate, 30 mg (gr ½),
(Warning: May be habit-forming);
and acetaminophen 300 mg.

C III

Wellcome

**Burroughs Wellcome Co.**
Research Triangle Park
North Carolina 27709

LIBRARY
MAR 13 198
NEW YORK ACADEMY
OF MEDICINE

IMJ
Illinois Medical Journal

JANUARY, 1978 Vol. 153, No. 1 CONTENTS

11 Abstracts of Board of Trustees Actions

*Clinical Articles*

27 Temporary Cardiac Pacing in a Community Practice
*by Donald M. Coder, M.D./Highland Park*

71 A Source of Wound Contamination Eliminated
*by Hugh A. Johnson, M.D./Rockford*

*Special Articles*

35 Radiology in Malpractice Cases
*by William A. Thomas, Ph.D., J.D./Chicago*

50 New Continuing Medical Education Regulations

*Convention Summary*

43 Summary of House of Delegates Actions: 1977 Interim Session

47 Actions on Resolutions

*Surgical Grand Rounds*

66 Case Report: Closed Mirtal Commisurotomy
*John M. Beal, M.D., Contributing Editor*

*Rheumatology Rounds*

83 Bilateral Knee Effusions in Sickle Cell Crisis
*L. F. Layfer, M.D., and J. V. Jones, M.D., Contributing Co-Editors*

*President's Page*

78 The Profession's Image
*George T. Wilkins, Jr., M.D.*

*(Contents continued on overleaf)*

## *Features*


| | |
|---|---|
| 6 | EKG of the Month |
| 14 | Housestaff News |
| 19 | Viewbox |
| 20 | Obituaries |
| 22 | Guest Editorial |
| 25 | New Pharmaceutical Specialties |
| 38 | Pulse of the ISMS Auxiliary |
| 39 | Clinics for Crippled Children |
| 40 | ISMS Guide to Continuing Medical Education |
| 59 | Physician Recruitment |
| 60 | Classified Advertising |
| 64 | Illinois Society, American Association of Medical Assistants |
| 79 | Doctor's News |


## *Staff*


**Managing editor** ..... **Richard A. Ott**

**Assistant editor** ..... **Mariann E. McGuire**

**Executive administrator** ..... **Roger N. White**


*(Cover by Alicia Albanese Kolton)*


### PUBLICATIONS COMMITTEE

Lawrence L. Hirsch, M.D., Chicago, *Chairman*
Kenneth A. Hurst, M.D., Naperville
Robert P. Johnson, M.D., Springfield
Alfred J. Kiessel, M.D., Decatur
Herman Wing, M.D., Chicago


---

Contributor in Surgery: John M. Beal, M.D., Chicago
Contributor in Maternal Death Studies: Robert Hartman, M.D., Jacksonville
Contributor in Pediatric Perplexities: Ruth Andrea Seeler, M.D., Chicago
Contributor in Radiology: Leon Love, M.D., Maywood
Contributor in Cardiology: John R. Tobin, M.D., Maywood
Contributor in Immunopathology: Richard J. Ablin, Ph.D., Chicago
Contributor in Rheumatology: L. F. Layfer, M.D., Chicago


### ILLINOIS STATE MEDICAL SOCIETY

#### OFFICERS

George T. Wilkins, M.D., President
3165 Myrtle, Granite City 62040
David S. Fox, M.D., President-Elect
826 E. 61st St., Chicago 60637
Theodore Grevas, M.D., 1st Vice-President
2701 17th St., Rock Island 61201
William M. Lees, M.D., 2nd Vice-President
6518 North Nokomis, Lincolnwood 60646
Eugene P. Johnson, M.D., Secretary-Treasurer
P.O. Box 68, Casey 62420

#### HOUSE OF DELEGATES

Cyril C. Wiggishoff, M.D., Speaker
25 E. Washington, Suite 1805, Chicago 60602
Robert P. Johnson, M.D., Vice Speaker
108 Maple Grove, Springfield 62707

#### TRUSTEES

1st District: 1980, John Ring, M.D.
Mundelein
2nd District: 1980, Allan L. Goslin, M.D.
712 N. Bloomington, Streator 61364
3rd District: 1980, Herschel Browns, M.D.
4600 N. Ravenswood, Chicago 60640
3rd District: 1979, Alfred Clementi, M.D.
675 W. Central Rd., Arlington Heights 60005
3rd District: 1980, Audley F. Connor, Jr., M.D.
3233 King Dr., Chicago 60616
3rd District: 1978, Harold J. Lasky, M.D.
55 E. Washington, Chicago 60602
3rd District: 1979, Robert T. Fox, M.D.
2136 Robincrest, Glenview 60025
3rd District: 1978, Henrietta Herbolsheimer, M.D.
5528 S. Hyde Park Blvd., Apt. 1202, Chicago 60637
3rd District: 1978, Lawrence L. Hirsch, M.D.
2434 Grace, Chicago 60618
3rd District: 1978, Eugene T. Hoban, M.D.
6429 North Ave., Oak Park 60302
3rd District: 1980, Joseph C. Sherrick, M.D.
303 E. Superior, Chicago 60611
3rd District: 1979, Herman Wing, M.D.
155 N. Narbor Dr., Chicago 60601
4th District: 1979, Fred Z. White, M.D.
723 N. 2nd St., Chillicothe 61523
5th District: 1979, Paul F. Mahon, M.D.
326 N. 7th St., Springfield 62702
6th District: 1978, Robert R. Hartman, M.D.
1515 A. W. Walnut, Jacksonville 62650
7th District: 1979, Alfred J. Kiessel, M.D.
1 Powers Lane Pl., Decatur 62521
8th District: 1979, James Laidlaw, M.D.
104 W. Clark, Champaign 61820
9th District: 1978, Warren D. Tuttle, M.D.
203 N. Vine St., Harrisburg 62946
10th District: 1978, Julian W. Buser, M.D.
6600 W. Main, Belleville 62223
11th District: 1980, Kenneth A. Hurst, M.D.
52 Bunting Lane, Naperville 60450
12th District: 1980, P. John Seward, M.D.
2400 N. Rockton, Rockford 61101
Trustee-At-Large: Joseph Skom, M.D.
707 Fairbanks Ct., Chicago 60611
Chairman of the Board: Robert T. Fox, M.D.
2136 Robincrest, Glenview 60025



Microfilm copies of current as well as some back issues of the *Illinois Medical Journal* may be purchased from Xerox University Microfilm, 300 North Zeeb Road, Ann Arbor, Mich. 48106.

Contents of *IMJ* are listed in the *Current Contents/Clinical Practice.*

Published by the Illinois State Medical Society, 55 E. Monroe St., Chicago, Ill. 60603 (312-782-1654)



Copyright, 1978. The Illinois State Medical Society. All material subject to this copyright may be photocopied for the noncommercial purpose of scientific or educational advancement.



Subscription $8.00 per year, in advance, postage prepaid, for the United States, Cuba, Puerto Rico, Philippine Islands and Mexico. $10.00 per year for all foreign countries included in the Universal Postal Union. Canada $8.50. U.S. Single current copies available at $1.00 ($1.10 by mail), back issues $1.50.

Second class postage paid at Chicago, Ill. When moving please notify Journal office of new address including old mailing label with notification, if possible. POSTMASTER: Send notice on form No. 3579 to Illinois State Medical Society, 55 E. Monroe St., Chicago, Ill. 60603.

Pharmaceutical advertising must be approved by the ISMS Publications Committee. Other advertising accepted after review by Publications Committee or Board of Trustees. All copy or plates must reach the Journal office by the fifteenth of the month preceding publication. Rates furnished upon request.

Original articles will be considered for publication with the understanding that they are contributed only to the *Illinois Medical Journal.* The ISMS denies responsibility for opinions and statements expressed by authors or in excerpts, other than editorial or allied views or statements which reflect the authoritative action of the ISMS or of reports on official actions, policies or positions. Views expressed by authors do not necessarily represent those of the Society; any connection with official policies is coincidental.

The *Illinois Medical Journal* is published by the Illinois State Medical Society as an educational and professional informational magazine and distributed as a benefit of membership in the Illinois State Medical Society. Its intent is to keep members current in medical knowledge and is a part of a continuing medical education program. Socioeconomic matters, affecting as they do a changing pattern in the proper delivery of medical care, are considered an inherent element in medical education.



# THE STRENGTH TO OVERCOME EXCESSIVE ANXIETY IN THE ELDERLY CARDIAC PATIENT.

**Before prescribing, please consult complete product information, a summary of which follows:**

**Indications:** Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders; athetosis; stiff-man syndrome; convulsive disorders (not for sole therapy).

**Contraindicated:** Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

**Warnings:** Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

**Precautions:** If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

**Side Effects:** Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

**VALIUM®**
**(diazepam) IV**

**2-MG TABLETS B.I.D. OR T.I.D.**

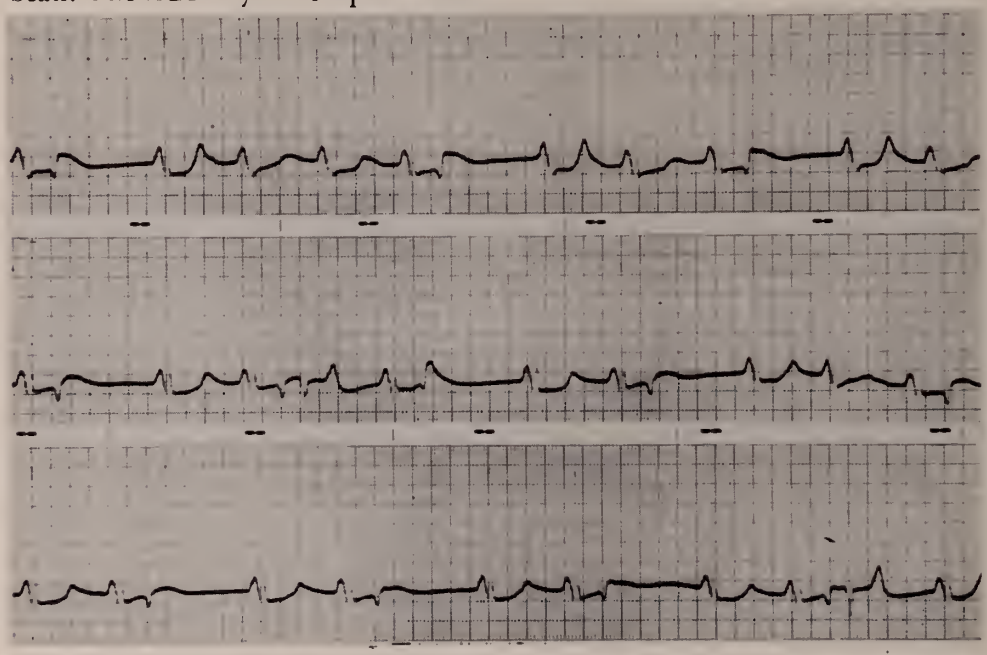
ROCHE

Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

# ekg of the month

John F. Moran, M.S., M.D., David L. Fishman, M.D.,
Patrick J. Scanlon, M.D., Sarah A. Johnson, M.D.,
John R. Tobin, M.S., M.D., and Rolf M. Gunnar, M.S., M.D.
Section of Cardiology, Department of Medicine,
Loyola University Stritch School of Medicine

This forty-year-old woman came to the office complaining of short episodes of palpitations, weakness, and light-headedness. The episodes were spontaneous and not related to any activity. In the past, the palpitations had occurred infrequently and for very brief periods, but now they were occurring daily and lasted up to one hour. Her physical examination was normal except for some premature beats. The ECG rhythm strip was taken.



**Questions:**

**1. The ECG shows:**

A. Premature ventricular beats.
B. A short PR interval of 0.10 seconds.
C. Retrograde P waves and occasional echo or reentry beats.
D. Prolonged Q-T interval.
E. All of the above.

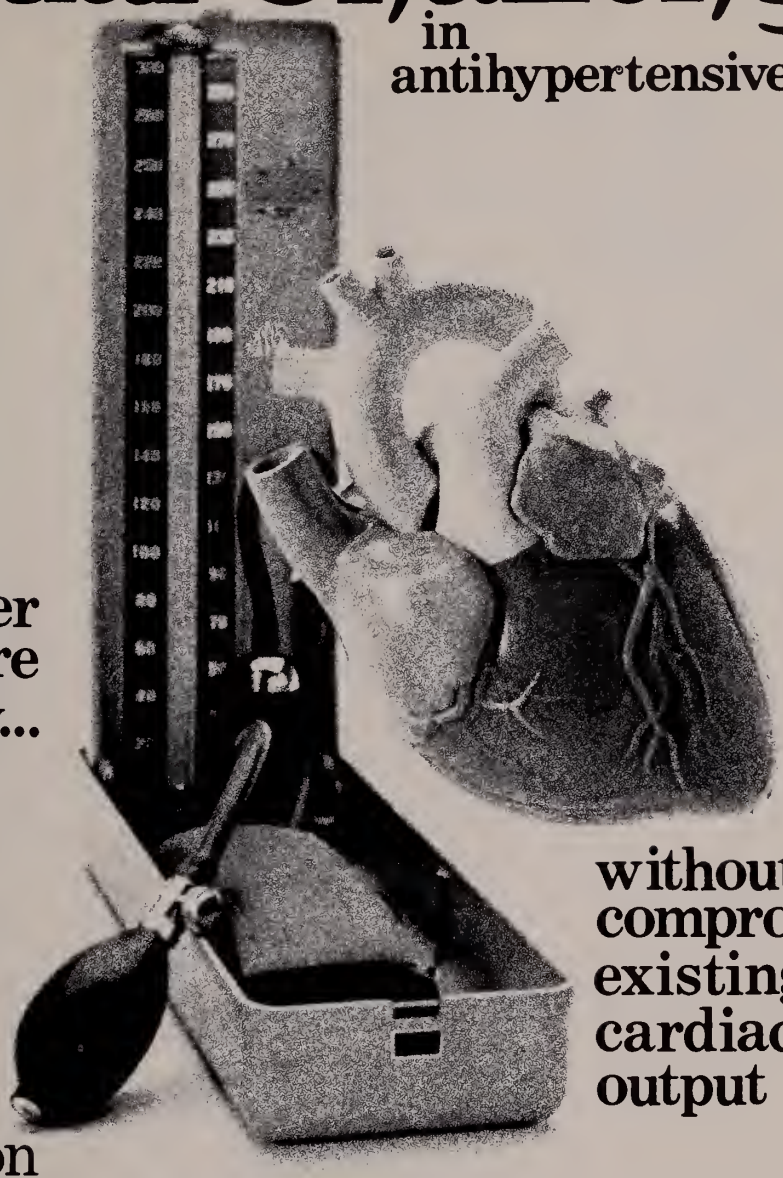
**2. Which of the following are true?**

A. The syndrome of short PR interval, normal QRS, and supraventricular tachycardias is called the Lown-Ganong-Levine syndrome.
B. Supraventricular tachycardia in this case could be due to atrionodal reentry.
C. An atrioventricular (A-V) nodal bypass tract is felt to be present in these patients.
D. Propranolol could be helpful.
E. All of the above.

*(Continued on page 54)*

# A Dual Challenge

in
antihypertensive therapy



to lower
blood pressure
effectively...

without
compromising
existing
cardiac
output

n hypertension

ABLETS: 250 mg, 500 mg, and 125 mg

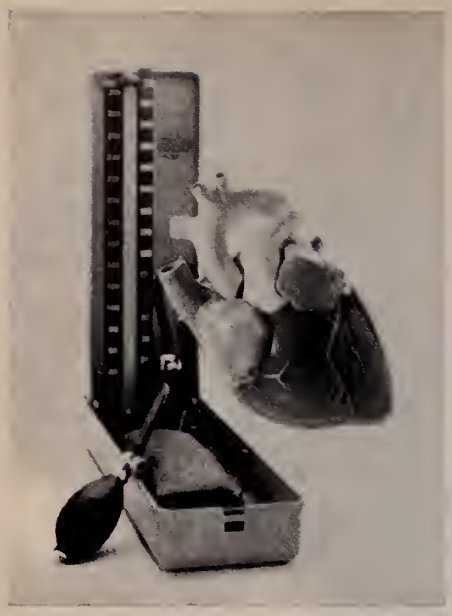
# ALDOMET® (METHYLDOPA | MSD)

helps lower blood pressure effectively...
usually with no direct effect on
cardiac function–cardiac output
s usually maintained

LDOMET is contraindicated in active hepatic disease, hypersensitivity to the drug, and if
revious methyldopa therapy has been associated with liver disorders.
is important to recognize that a positive Coombs test, hemolytic anemia, and liver disorders
ay occur with methyldopa therapy. The rare occurrences of hemolytic anemia or liver disorders
ould lead to potentially fatal complications unless properly recognized and managed. For more
etails see the brief summary of prescribing information.

**or a brief summary of prescribing information, please see following page.**

MSD
MERCK
SHARP &
DOHME



in hypertension

# ALDOMET®

## (METHYLDOPA|MSD)

helps lower blood pressure effectively... usually with no direct effect on cardiac function– cardiac output is usually maintained

**Contraindications:** Active hepatic disease, such as acute hepatitis and active cirrhosis; if previous methyldopa therapy has been associated with liver disorders (see Warnings); hypersensitivity.

**Warnings: It is important to recognize that a positive Coombs test, hemolytic anemia, and liver disorders may occur with methyldopa therapy. The rare occurrences of hemolytic anemia or liver disorders could lead to potentially fatal complications unless properly recognized and managed. Read this section carefully to understand these reactions.**

With prolonged methyldopa therapy, 10% to 20% of patients develop a positive direct Coombs test, usually between 6 and 12 months of therapy. Lowest incidence is at daily dosage of 1 g or less. This on rare occasions may be associated with hemolytic anemia, which could lead to potentially fatal complications. One cannot predict which patients with a positive direct Coombs test may develop hemolytic anemia. Prior existence or development of a positive direct Coombs test is not in itself a contraindication to use of methyldopa. If a positive Coombs test develops during methyldopa therapy, determine whether hemolytic anemia exists and whether the positive Coombs test may be a problem. For example, in addition to a positive direct Coombs test there is less often a positive indirect Coombs test which may interfere with cross matching of blood.

At the start of methyldopa therapy, it is desirable to do a blood count (hematocrit, hemoglobin, or red cell count) for a baseline or to establish whether there is anemia. Periodic blood counts should be done during therapy to detect hemolytic anemia. It may be useful to do a direct Coombs test before therapy and at 6 and 12 months after the start of therapy. If Coombs-positive hemolytic anemia occurs, the cause may be methyldopa and the drug should be discontinued. Usually the anemia remits promptly. If not, corticosteroids may be given and other causes of anemia should be considered. If the hemolytic anemia is related to methyldopa, the drug should not be reinstituted. When methyldopa causes Coombs positivity alone or with hemolytic anemia, the red cell is usually coated with gamma globulin of the IgG (gamma G) class only. The positive Coombs test may not revert to normal until weeks to months after methyldopa is stopped.

Should the need for transfusion arise in a patient receiving methyldopa, both a direct and an indirect Coombs test should be performed on his blood. In the absence of hemolytic anemia, usually only the direct Coombs test will be positive. A positive direct Coombs test alone will not interfere with typing or cross matching. If the indirect Coombs test is also positive, problems may arise in the major cross match and the assistance of a hematologist or transfusion expert will be needed.

Fever has occurred within first 3 weeks of therapy, occasionally with eosinophilia or abnormalities in liver function tests, such as serum alkaline phosphatase, serum transaminases (SGOT, SGPT), bilirubin, cephalin cholesterol flocculation, prothrombin time, and bromsulphalein retention. Jaundice, with or without fever, may occur, with onset usually in the first 2 to 3 months of therapy. In some patients the findings are consistent with those of cholestasis. Rarely fatal hepatic necrosis has been reported. These hepatic changes may represent hypersensitivity reactions; periodic determination of hepatic function should be done particularly during the first 6 to 12 weeks of therapy or whenever an unexplained fever occurs. If fever and abnormalities in liver function tests or jaundice appear, stop therapy with methyldopa. If caused by methyldopa, the temperature and abnormalities in liver function characteristically have reverted to normal when the drug was discontinued. Methyldopa should not be reinstituted in such patients.

Rarely, a reversible reduction of the white blood cell count with primary effect on granulocytes has been seen. Reversible thrombocytopenia has occurred rarely. When used with other antihypertensive drugs, potentiation of antihypertensive effect may occur. Patients should be followed carefully to detect side reactions or unusual manifestations of drug idiosyncrasy.

*Pregnancy and Nursing:* Use of any drug in women who are or may become pregnant or intend to nurse requires that anticipated benefits be weighed against possible risks; possibility of fetal injury or injury to a nursing infant cannot be excluded. Methyldopa crosses the placental barrier, appears in cord blood, and appears in breast milk.

**Precautions:** Should be used with caution in patients with history of previous liver disease or dysfunction (see Warnings). May interfere with measurement of: urinary uric acid by the phosphotungstate method, serum creatinine by the alkaline picrate method, and SGOT by colorimetric methods. Since methyldopa causes fluorescence in urine samples at the same wavelengths as catecholamines, falsely high levels of urinary catecholamines may be reported. This will interfere with the diagnosis of pheochromocytoma. It is important to recognize this phenomenon before a patient with a possible pheochromocytoma is subjected to surgery. Methyldopa is not recommended for patients with pheochromocytoma. Urine exposed to air after voiding may darken because of breakdown of methyldopa or its metabolites.

Stop drug if involuntary choreoathetotic movements occur in patients with severe bilateral cerebrovascular disease. Patients may require reduced doses of anesthetics; hypotension occurring during anesthesia usually can be controlled with vasopressors. Hypertension has recurred after dialysis in patients on methyldopa because the drug is removed by the procedure.

**Adverse Reactions:** *Central nervous system:* Sedation, headache, asthenia or weakness, usually early and transient; dizziness, lightheadedness, symptoms of cerebrovascular insufficiency, paresthesias, parkinsonism, Bell's palsy, decreased mental acuity, involuntary choreoathetotic movements; psychic disturbances, including nightmares and reversible mild psychoses or depression.

*Cardiovascular:* Bradycardia, aggravation of angina pectoris. Orthostatic hypotension (decrease daily dosage). Edema (and weight gain) usually relieved by use of a diuretic. (Discontinue methyldopa if edema progresses or signs of heart failure appear.)

*Gastrointestinal:* Nausea, vomiting, distention, constipation, flatus, diarrhea, mild dryness of mouth, sore or "black" tongue, pancreatitis, sialadenitis.

*Hepatic:* Abnormal liver function tests, jaundice, liver disorders.

*Hematologic:* Positive Coombs test, hemolytic anemia. Leukopenia, granulocytopenia, thrombocytopenia. Positive tests for antinuclear antibody, LE cells, and rheumatoid factor.

*Allergic:* Drug-related fever, lupus-like syndrome, myocarditis.

*Other:* Nasal stuffiness, rise in BUN, breast enlargement, gynecomastia, lactation, impotence, decreased libido, dermatologic reactions including eczema and lichenoid eruptions, mild arthralgia, myalgia.

**Note:** Initial adult dosage should be limited to 500 mg daily when given with antihypertensives other than thiazides. Tolerance may occur, usually between second and third months of therapy; increased dosage or adding a diuretic frequently restores effective control. Patients with impaired renal function may respond to smaller doses. Syncope in older patients may be related to increased sensitivity and advanced arteriosclerotic vascular disease; this may be avoided by lower doses.

**How Supplied:** Tablets, containing 125 mg methyldopa each, in bottles of 100; Tablets, containing 250 mg methyldopa each, in single-unit packages of 100 and bottles of 100 and 1000; Tablets, containing 500 mg methyldopa each, in single-unit packages of 100 and bottles of 100 and 500.

*For more detailed information, consult your MSD representative or see full prescribing information.*
*Merck Sharp & Dohme, Division of Merck & Co., Inc., West Point, Pa. 19486*

J6AM07R1(709)

**MSD** MERCK SHARP & DOHME

Blue Cross® Blue Shield®

# REPORT FOR *Illinois Physicians*

## NEW BELL TELEPHONE BENEFIT ADJUSTMENTS

Effective January 1, 1978 adjustments have been made in covered services and payment levels to the Illinois Bell Telephone Company and Bell Laboratories health care programs. The changes apply to Group #35500 and Group #51100 of Illinois Bell Telephone Company and to the Central Certification Group (LAB #303) of Bell Laboratories.

• *Pregnancy Waiting Period Eliminated*—The 270-day waiting period for pregnancy benefits has been removed and benefits begin with the effective date of the patient's coverage.

• *Elective Surgical Additional Opinion Consultations*—Blue Shield will pay the *billed charges* for elective surgical second opinion consultations. The Usual and Customary payment basis will not be used.

The benefit comprises one consultation by a qualified specialist with whom the Plan has an agreement for rendering the service. The service must be requested by the member and be arranged through the Plan.

If requested, an additional consultation will be provided when the need for surgery is not confirmed by the first consultation.

When X-ray, laboratory or pathological examinations are required, they are in benefit as part of the consultation services.

• *Chemotherapy Benefits*—Chemotherapy benefits have been broadened and are restated as follows: Benefits are to be provided for the treatment of malignant diseases wherever rendered—inhospital or outpatient treatment, in a physician's office or patient's home. Coverage will be provided for oral, intravenous, subcutaneous, intraarterial or intramuscular administration.

Benefits include charges for both administration and drugs when not covered by the Basic Hospital Service Contract. Drugs no longer required, effective or experimental will not be covered unless accepted by the appropriate government agency having jurisdiction in this area.

Reimbursement for chemotherapy services will be as follows:

1) *Hospital Inpatient*—Services paid in full under Blue Cross provided patient is receiving services during a covered hospital admission.

2) *Hospital Outpatient*—90% of Usual and Customary allowance for chemical agent and administration, provided services are performed by hospital employee and billed by the hospital.

3) *Physician's Office*—90% of Usual and Customary allowance for chemical agent and administration charge, but not the charge for the office visit.

4) *Home*—90% of Usual and Customary allowance for the chemical agent. Supplies required for administration will be paid at 90% of Usual and Customary charge. No professionally billed charges are in benefit for administration in this situation.

• *Pre Admission Testing*—Physician-ordered tests performed preliminary to admission as a bed patient for surgery are in benefit provided that:

1) The tests are necessary for and consistent with the diagnosis and treatment of the condition for which surgery is to be performed; and

2) Reservations for a hospital bed and operating room shall have been made prior to performance of the tests within a time that permits the tests to be medically valid at the time of admission for surgery; and

3) The member is physically present at the hospital for the tests; and

4) The surgery is not cancelled or postponed other than as a result of the pre-admission test findings, as a result of an Elective Surgical Additional Opinion Consultation or because of the lack of hospital facilities at the time of admission.

• *Registered Clinical Psychologists*—The services of a registered clinical psychologist will be in benefit effective January 1, 1978.

• *Coverage of Pap Smears*—Under diagnostic and x-ray benefits, Pap smears will be covered when *not* performed as part of a battery of tests during a routine physical examination or check-up.

## Medicare to Follow Blue Shield's Medical Necessity Program

An announcement made in May, 1977 by the Blue Shield Association, after consultation with medical specialty societies and health care professional organizations, stated that Blue Shield would no longer routinely pay for certain named surgical and diagnostic procedures. Medicare is now also following this policy.

There may be situations when some of the procedures are medically justified. Medicare is therefore requesting physicians to include on their Medicare forms, or submit along with their bills, a statement indicating why a procedure on the following list is medically necessary. The statement will be reviewed by the medical staff.

After the statement from the physician is reviewed by the medical staff, a decision will be made whether to pay or deny payment of the procedure.

It will, therefore, be to the physician's advantage and to the advantage of the patient to consider the medical necessity of the listed procedures prior to their being performed. In the interest of high quality medical care at appropriate costs, Medicare is seeking the physician's cooperation in this mutually advantageous program.

If you have any medical questions relating to the Medical Necessity Program, please direct them to the Medical Department, Blue Cross and Blue Shield, 233 North Michigan Avenue, Chicago, Illinois 60601. Non-medical questions may be directed to our Professional Relations Department.

Each of the following procedures require a statement from the physician indicating why it was medically necessary.

### PROCEDURES

Bronchoscopy—for sole purpose of injection of contrast medium for bronchography
Bronchoscopy—for sole purpose of injection of radioactive substance
Ligation of internal mammary arteries, unilateral and bilateral
Radical hemorrhoidectomy, Whitehead type, including removal of entire pile bearing area
Omentopexy for establishing collateral circulation in portal obstruction
Kidney decapsulation, unilateral and bilateral
Perirenal insufflation
Nephropexy: fixation or suspension of kidney (independent procedure), unilateral
Circumcision, female
Hysterotomy, non-obstetrical, vaginal
Fabric wrapping of abdominal aneurysm
Supracervical hysterectomy: subtotal hysterectomy, with or without tubes and/or ovaries, one or both
Uterine suspension (independent procedure)
Uterine suspension, with presacral sympathectomy (independent procedure)
Ligation of thyroid arteries (independent procedure)
Hypogastric or presacral neurectomy (independent procedure)
Angiocardiography, single plane and multi-plane, in conjunction with cineradiography
Angiocardiography, utilizing $CO_2$ method
Angiography—coronary, unilateral selective injection, single view unless emergency
Angiography—extremity, unilateral, single view unless emergency
Protein bound iodine (PBI)
Icterus index
Basal metabolic rate (BMR)
Phonocardiogram with indirect carotid artery tracing or similar study
Ballistocardiogram

| Procedures: | For Sole Purpose of Treating: |
|---|---|
| Fascia lata by stripper | Lower back pain |
| Fascia lata by incision and area exposure, with removal of sheath | Lower back pain |
| Ligation of femoral vein, unilateral and bilateral | Post-phlebitic syndrome |
| Excision of carotid body tumor | Asthma |
| without excision of carotid artery | |
| with excision of carotid artery | |
| Sympathectomy, thoracolumbar, unilateral and bilateral | Hypertension |
| Sympathectomy, lumbar, unilateral and bilateral | Hypertension |
| Splanchnicectomy, unilateral and bilateral | Hypertension |
| Extra-intra cranial arterial bypass | Complete Stroke |

## Changes in Lab Participation in the Medicare Program

The Bureau of Health Insurance, Social Security Administration, has issued notices that the following laboratories are closed or have ceased operations and that no payment can be made under the health insurance program for services rendered on or after notification date. The laboratories are:
(Closed):

P.M. Clinical Laboratory
6160 Joliet Road
Countryside, Ill. 60525
Provider Number: 14-8205
Effective Date: September 1, 1977

(Ceased Operations).
Delta Medical Laboratory
4255 West 63rd Street
Chicago, Ill. 60629
Provider No. 14-8338
Effective Date: November 1, 1977

# *Abstracts of Board Actions*

**November 11-13, 1977** **St. Louis**

*These abstracts are published so that members of the Illinois State Medical Society may keep advised of the actions of the Board of Trustees. It covers only major actions and is not intended as a detailed report. Full minutes of the meetings are available upon any member's request to the headquarters office of the ISMS.*

## Purchase Springfield Building

The Board approved the purchase of a one-story building at 701 S. Second St., Springfield, to house the Society's regional office. Because interior renovation is needed to meet ISMS requirements, the Society is not expected to assume occupancy until early 1978. Purchase of the building—one block from the Capitol—was in response to a House of Delegates' directive to seek adequate office space in Springfield.

## Assist with Court Brief, Countersuit

ISMS will provide financial assistance in support of an Illinois Psychiatric Society amicus curiae brief in a case involving confidentiality of patient records. A Cook County Grand Jury is seeking patient records from Chicago Lake Shore Hospital in investigating alleged fraudulent billing and excessive use of electric shock therapy. Attorneys for the hospital and physicians have filed for an injunction on grounds that release of records would represent an invasion of privacy and violate Illinois statute establishing as privileged the communications between psychiatrists and their patients. ISMS will support the brief because a court decision allowing government access to patient records would set a precedent, and possibly stimulate litigation against physicians and hospitals.

ISMS also will provide assistance in the countersuit of a Chicago-area ophthalmologist. The original suit against the physician was dismissed when the plaintiff's attorney failed to produce an expert witness to testify for the plaintiff. The countersuit affords an opportunity to challenge Illinois requirements for countersuits based upon malicious prosecution and proof of special damages.

In both cases—the amicus curiae brief and the countersuit—ISMS aid falls within guidelines governing legal assistance adopted by the Board last August.

## Blue Shield's Medical Necessity Program

Blue Shield will be asked to consult ISMS prior to implementing any new elements of a program which requires physicians to provide written justification prior to receiving payment for 28 procedures. The procedures have been classified as: (1) New procedures of unproven value; (2) Established procedures of questionable usefulness; (3) Procedures which tend to be redundant when performed in combination with other procedures; or (4) Diagnostic procedures that are unlikely to provide additional information when repeated frequently.

*(Continued on page 55)*

# *Clinical experience & continuing confidence*

KAON® ELIXIR was introduced in **1954,** followed by KAON® TABLETS in **1963.** Decades of clinical experience indicate acceptability, effectiveness, and safety in the majority of patients; should abdominal pain occur, therapy should be discontinued. Both have been taken by patient after patient, day after day, year after year, to correct potassium deficiencies. Both have consistently demonstrated their value when diet alone is inadequate for potassium replacement.

## Kaon® Elixir
(potassium gluconate)

## Kaon® Tabs
(potassium gluconate)

BRIEF SUMMARY
**Kaon Tablets/Kaon Elixir**

**KAON® (potassium gluconate) TABLETS**

**Description:** Each sugar-coated tablet supplies 5 mEq. of elemental potassium (as potassium gluconate 1.17 Gm.). Kaon Tablets are sugar coated, not enteric coated, which favors dissolution in the stomach and absorption before reaching the small intestine where the lesions with enteric potassium chloride have occurred. The sugar coating merely adds to palatability and ease of swallowing, not to delay absorption as does the enteric coating.
**Indications:** Oral potassium therapy for the prevention and treatment of hypokalemia which may occur secondary to diuretic or corticosteroid administration. It may be used in the treatment of cardiac arrhythmias due to digitalis intoxication.
**Contraindications:** Severe renal impairment with oliguria or azotemia, untreated Addison's disease, adynamia episodica hereditaria, acute dehydration, heat cramps and hyperkalemia from any cause.
**Warning:** There have been several reports, published and unpublished, concerning nonspecific small-bowel lesions consisting of stenosis, with or without ulceration, associated with the administration of enteric-coated potassium tablets alone or when they are used with nonenteric-coated thiazides or certain other oral diuretics. These small-bowel lesions have caused obstruction, hemorrhage and perforation. Surgery was frequently required and deaths have occurred. Available information tends to implicate enteric-coated potassium salts, although lesions of this type also occur spontaneously. Therefore, coated potassium-containing formulations should be administered only when indicated and should be discontinued immediately if abdominal pain, distention, nausea, vomiting, or gastrointestinal bleeding occur. Coated potassium tablets should be used only when adequate dietary supplementation is not practical.
**Precautions:** In response to a rise in the concentration of body potassium, renal excretion of the ion is increased. With normal kidney function, it is difficult, therefore, to produce potassium intoxication by oral administration. However, potassium supplements must be administered with caution, since the amount of the deficiency or daily dosage is not accurately known. Frequent checks of the clinical status of the patient, and periodic ECG and/or serum potassium levels should be made. High serum concentra-

*Time is the test of all things*



tions of potassium ion may cause death through cardiac depression, arrhythmias or arrest. This drug should be used with caution in the presence of cardiac disease.

In hypokalemic states, especially in patients on a salt-free diet, hypochloremic alkalosis is a possibility that may require chloride as well as potassium supplementation. In these circumstances, Kaon (potassium gluconate) should be supplemented with chloride. Ammonium chloride is an excellent source of chloride ion (18.7 mEq. per Gram), but it should not be used in patients with hepatic cirrhosis where ammonium salts are contraindicated. Other sources for chloride are sodium chloride and Diluted Hydrochloric Acid, U.S.P.

It should also be kept in mind that ammonium cycle cation exchange resin, sometimes used to treat hyperkalemia, should not be administered to patients with hepatic cirrhosis.

**Adverse Reactions:** Nausea, vomiting, diarrhea and abdominal discomfort have been reported. The symptoms and signs of potassium intoxication include paresthesias of the extremities, flaccid paralysis, listlessness, mental confusion, weakness and heaviness of the legs, fall in blood pressure, cardiac arrhythmias and heart block. Hyperkalemia may exhibit the following electrocardiographic abnormalities: disappearance of the P wave, widening and slurring of QRS complex, changes of the S-T segment, tall peaked T waves, etc.

**Overdosage:** Potassium intoxication may result from overdosage of potassium or from therapeutic dosage in conditions stated under "Contraindications." Hyperkalemia, when detected, must be treated immediately because lethal levels can be reached in a few hours.

**KAON® (potassium gluconate) ELIXIR**

**Description:** Each 15 ml. (tablespoonful) supplies 20 mEq. of elemental potassium (as potassium gluconate, 4.68 Gm.) with saccharin and aromatics. Alcohol 5%.

**Indications:** See Kaon Tablets.

**Precautions:** See Kaon Tablets.

In hypochloremic alkalosis, potassium replacement with potassium chloride (e.g., Kaochlor® 10% Liquid) may be more advantageous than with other potassium salts.

**Adverse Reactions:** See Kaon Tablets.

**Overdosage:** See Kaon Tablets.

**WARREN-TEED**
PHARMACEUTICALS INCORPORATED
COLUMBUS, OHIO 43215




# Resident Musings on the Mechanics of Organized Medicine

By Linda L. Hughey, M.D./Wilmette

*This is a monthly column which welcomes contributions, comments, and questions from interested readers. Address all correspondence to Dr. Linda Hughey, c/o the Illinois Medical Journal, 55 E. Monroe, Chicago, Ill. 60603.*

Before attending both the ISMS interim convention (St. Louis, Nov. 12-13) and the AMA Resident Physician Section of the AMA interim meeting (Chicago, Dec. 2-3) I had suspected that little happened at such gatherings. After attending two of them, I still wonder exactly what goes on, but sense that, like the proverbial iceberg, the bulk of the action is under water.

The format of the conventions involves large meetings of delegates voting on motions proposed by individuals and revised by reference committees. The action is rarely on the house of delegates' floor but rather in the hospitality suites and special meetings of smaller groups. Most of the unofficial action involves individuals making contact and getting to know one another. The official actions involved one of the following:

(1) The AMA (or ISMS) should "support" something.
(2) The AMA (or ISMS) should "study" something and report at the next meeting.
(3) Committee appointments and officer elections.

The reference committees do much of the work of drafting proposals; the majority of research is done by AMA (or ISMS) staff, and the consulting is done by free-standing committees.

What happens to the proposals? Well, I shall have to report on that next year. A finished example of an AMA-RPS activity is the "Opinions of Resident Physicians" booklet published this year by the AMA in response to a December, 1975, request by the RPS to poll its membership. The AMA polled some 10,000 of the nation's 48,000 residents regarding their residency programs. The results are interesting but hardly surprising.

As the "most important" feature of a residency program, (1) attending staff, (2) program director and (3) number and kind of patients, received the highest ratings. Major problems cited in residency programs were (1) excess "service" (i.e. not educational) emphasis, (2) excess call, and (3) unavailability of services and support mechanisms (this is evidently the "patient care" issue over which Cook County Hospital housestaff repeatedly threaten to go on strike). Although a majority (65%) had housestaff associations at their hospitals, a majority of residents also felt that the Housestaff Association did *not* contribute to the success of the program or to securing desirable features in the program. The most important factors cited by residents in choosing a program were: (1) specialty (2) reputation of hospital, (3) hospital staff.

The survey also queried Housestaff on salary; the average was $14,291; Psychiatry at $15,122 and Radiology at $14,878 were the highest-paying specialty programs. Average salaries were slightly higher among AMA members than non-AMA member residents. The East North Central states (including Illinois) logged in slightly below the national average at $14,086.

"The Opinions of Resident Physicians" (AMA, 1977) is hardly earthshattering but fairly interesting. This particular product of a convention brain child was two years in coming to fruition; many activities of the medical societies both at a state and national level evolve only over the course of years. Which is one reason why it is difficult for us as house staff to appreciate Medical Society activities. Furthermore, the effects of the organized medical groups are subtle; they occur in the form of individual testimony, research, discussions, and contacts. Perhaps if we present residents are practicing medicine for twenty years we shall come to appreciate the more subtle activities of the AMA. Maybe . . . if there is still a recognizable "practice of medicine" twenty years from now.

"California cardiologists offer advice on how to deal with liquid protein-diet side effects... major medical centers report on the emerging clinical role of ultrasound... pediatricians would ban trampolines... proposed legislation gives the FDA more authority over physician-prescribing..."

**Important things are happening that you should know about right away. You'll find them on your desk every two weeks in Medical World News, the newsmagazine of medicine.**

**Read this one first.**

**medical world news**

A McGraw-Hill publication

McGraw-Hill

# A New Vision of Catapres® (clonidine HCl)

# 20/20



## The first 20 days

- Catapres lowers blood pressure promptly.
- No contraindications.
- Some patients may have dry mouth, drowsiness, and sedation. Tell them that these tend to diminish with continued use.
- Giving the larger part of the divided dose at bedtime can help alleviate drowsiness and sedation.

## The next 20 years*

- Lowered blood pressure.
- Little impotence, depression or postural hypotension.
- No fatal hepatotoxicity in over a decade of worldwide use.
- Broad therapeutic dosage range to keep step with changing dosage needs over the years.

*Tolerance may develop in some patients, necessitating a reevaluation of therapy.

For full details on adverse reactions, warnings and precautions, see brief summary of the prescribing information on last page of this advertisement.



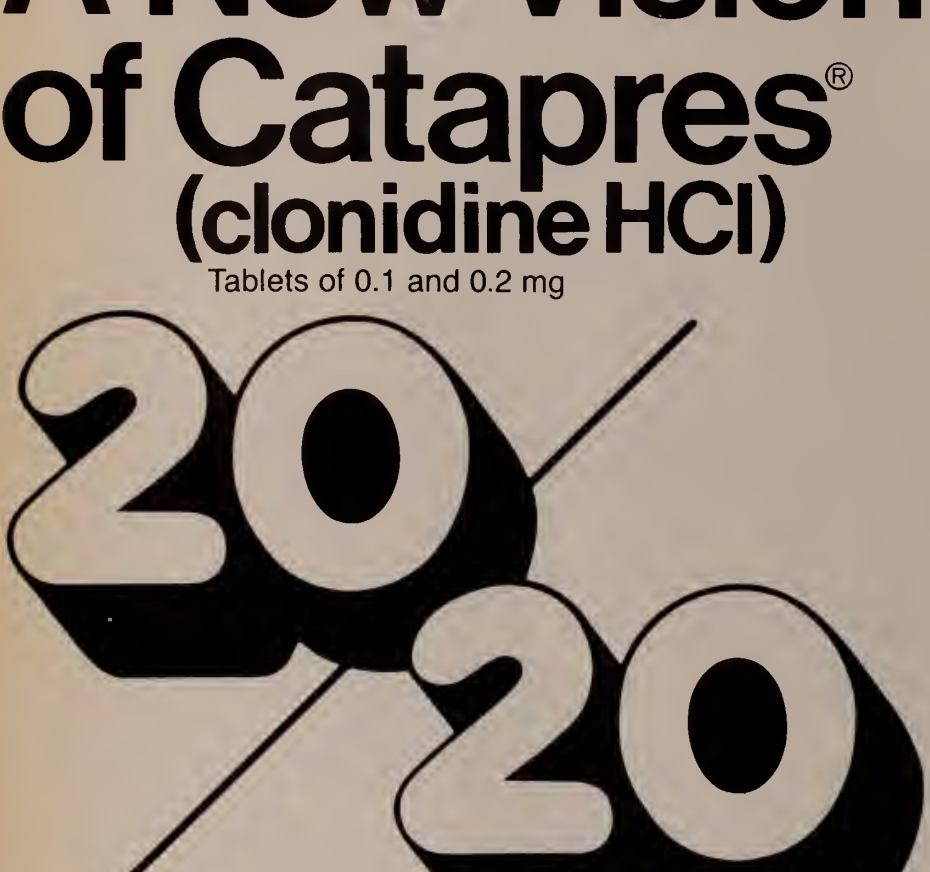
**Catapres®** (clonidine HCl)
**For Step 2 in Hypertension**

HYPERTENSION

# A New Vision of Catapres®

## (clonidine HCl)

Tablets of 0.1 and 0.2 mg




## What you do the first 20 days Can help him the next 20 years

**Catapres®**
**(clonidine hydrochloride)**
Tablets of 0.1 mg and 0.2 mg

**Indication:** The drug is indicated in the treatmen hypertension. As an antihypertensive drug, Catap (clonidine hydrochloride) is mild to moderate in p It may be employed in a general treatment progra with a diuretic and/or other antihypertensive age as needed for proper patient response.

**Warnings:** Tolerance may develop in some patien necessitating a reevaluation of therapy.
*Usage in Pregnancy:* In view of embryotoxic findi animals, and since information on possible adver effects in pregnant women is limited to uncontrol clinical data, the drug is not recommended in wo who are or may become pregnant unless the pote benefits outweigh the potential risk to mother an *Usage in Children:* No clinical experience is avai with the use of Catapres (clonidine hydrochloride children.

**Precautions:** When discontinuing Catapres (clon hydrochloride), reduce the dose gradually over 2 4 days to avoid a possible rapid rise in blood pre and associated subjective symptoms such as ner ness, agitation, and headache. Patients should b instructed not to discontinue therapy without con their physician. Rare instances of hypertensive e lopathy and death have been recorded after cess of clonidine hydrochloride therapy. A causal rela ship has not been established in these cases. It been demonstrated that an excessive rise in bloo sure, should it occur, can be reversed by resump of clonidine hydrochloride therapy or by intrave- nous phentolamine. Patients who engage in pote tially hazardous activities, such as operating ma or driving, should be advised of the sedative effe This drug may enhance the CNS-depressive effe alcohol, barbiturates and other sedatives. Like a agent lowering blood pressure, clonidine hydroc should be used with caution in patients with sev coronary insufficiency, recent myocardial infarct cerebrovascular disease or chronic renal failure.

As an integral part of their overall long-term c patients treated with Catapres (clonidine hydroc should receive periodic eye examinations. While except for some dryness of the eyes, no drug-rel abnormal ophthalmologic findings have been rec with Catapres (clonidine hydrochloride), in sever studies the drug produced a dose-dependent inc in the incidence and severity of spontaneously o ring retinal degeneration in albino rats treated fo 6 months or longer.

**Adverse Reactions:** The most common reactions dry mouth, drowsiness and sedation. Constipatio dizziness, headache, and fatigue have been repo Generally these effects tend to diminish with co therapy. The following reactions have been asso with the drug, some of them rarely. (In some ins an exact causal relationship has not been establ These include: Anorexia, malaise, nausea, vomit parotid pain, mild transient abnormalities in live tion tests; one report of possible drug-induced h titis without icterus and hyperbilirubinemia in a receiving clonidine hydrochloride, chlorthalidon papaverine hydrochloride. Weight gain, transient tion of blood glucose, or serum creatine phosph congestive heart failure, Raynaud's phenomenon dreams or nightmares, insomnia, other behavior changes, nervousness, restlessness, anxiety and depression. Also rash, angioneurotic edema, hiv urticaria, thinning of the hair, pruritus not assoc with a rash, impotence, urinary retention, increa sensitivity to alcohol, dryness, itching or burning eyes, dryness of the nasal mucosa, pallor, gynec mastia, weakly positive Coombs' test, asymptom electrocardiographic abnormalities manifested a Wenckebach period or ventricular trigeminy.

**Overdosage:** Profound hypotension, weakness, s lence, diminished or absent reflexes and vomitin lowed the accidental ingestion of Catapres (clon hydrochloride) by several children from 19 month 5 years of age. Gastric lavage and administratio analeptic and vasopressor led to complete recov within 24 hours. Tolazoline in intravenous doses 10 mg at 30-minute intervals usually abolishes a fects of Catapres (clonidine hydrochloride) overd

**How Supplied:** Catapres, brand of clonidine hyd chloride, is available as 0.1 mg (tan) and 0.2 mg (orange) oval, single-scored tablets in bottles of and 1000.

For complete details, please see full prescribi information.

Under license from Boehringer Ingelheim Gmb

Boehringer Ingelheim Ltd.
Ridgefield, CT. 06877



# the view box

Leon Love, M.D./Chairman/Department of Radiology
Loyola University Stritch School of Medicine

This patient is a markedly obese female with complaints of indigestion and pain after eating. An oral cholecystogram was done with a total of 18 tablets over a three day period. (Figure 1)



**Figure 1**

## *What's your diagnosis?*

*(Continued on page 62)*

# *Obituaries*

°**Arnold, Arthur,** Hinsdale, died November 8 at the age of 56. Doctor Arnold was a 1946 graduate of Harvard Medical School.

°**Bond, Ian H.,** Ormond Beach, Florida, formerly of Chicago, died October 28 at the age of 80. Doctor Bond was a 1928 graduate of Rush Medical College.

°**DeFeo, Herman F.,** Chicago, died December 7 at the age of 70. Doctor DeFeo was a 1933 graduate of Loyola University Medical School.

°°**Everhart, Arley Glenn,** Lake Worth, Florida, formerly of Buda, died October 27 at the age of 86. Doctor Everhart was a 1916 graduate of The Chicago College of Medicine & Surgery.

**Farnsworth, Edith Brooks,** Florence, Italy, formerly of Plano, died December 4 at the age of 74. Doctor Farnsworth was a 1939 graduate of Northwestern University.

°**Farrell, James T.,** Evanston, died October 30 at the age of 77. Doctor Farrell was a 1929 graduate of Rush Medical College.

°**Harman, David S.,** Chicago, died September 29 at the age of 69. Doctor Harman was a 1933 graduate of Northwestern University.

°**Kravitz, Harvey,** Chicago, died December 5 at the age of 57. Doctor Kravitz was a 1944 graduate of the University of Illinois. Doctor Kravitz, a former pediatric and medical progress contributor for the IMJ, practiced at both Lutheran General Hospital in Park Ridge and the Northwestern University Medical Center. He served also on the National Accident Prevention Committee for the American Academy of Pediatrics and the Child Health Committee of the National Safety Council.

°**Kielsmeier, Calvin E.,** Elgin, died December 12 at the age of 70. Doctor Kielsmeier was a 1936 graduate of the Chicago Medical School.

°**Kolomijcew, Lydia,** Downers Grove, died December 3 at the age of 60. Doctor Kolomijcew was a 1948 graduate from Erlangen Bayern, Germany.

°**Lawrence, Walter,** Berwyn, died November 17 at the age of 88. Doctor Lawrence was a 1926 graduate of the Chicago Medical College.

°**Lichtenstein, Manuel E.,** Chicago, died December 3 at the age of 77. Doctor Lichtenstein was a 1925 graduate of Rush Medical College.

**McDonald, Owen G.,** Lake Forest, died November 19 at the age of 65.

°**McMorris, Rex O.,** Peoria, died December 6 at the age of 65. Doctor McMorris was a 1949 graduate of the University of Nebraska.

°°**Nowak, Stanislaus,** Chicago, died November 2 at the age of 81. Doctor Nowak was a 1919 graduate of State University, Buffalo, NY.

°**Padorr, Marvin P.,** Long Beach, California, formerly of Chicago, died November 11 at the age of 59. Doctor Padorr was a 1941 graduate of the University of Illinois.

**Phillips, Jack,** Chicago, died early in November of this year.

°**Rayson, Edwin Hope,** Knoxville, Tenn., formerly of Earlville, died November 17 at the age of 80. Doctor Rayson was a 1922 graduate of Loyola University.

°°**Smith, Groves B.,** Alton, died July 13 at the age of 85. Doctor Smith was a 1916 graduate of Columbia University College of Physicians & Surgeons.

*°Indicates ISMS member.*
*°°Indicates member of the ISMS Fifty Year Club.*





**Cardilate® (erythrityl tetranitrate)**
INDICATIONS For the prophylaxis and long t
treatment of patients with frequent or recurren
anginal pain and reduced exercise tolerance
associated with angina pectoris, rather than fo
the treatment of the acute attack of angina pect
since its onset is somewhat slower than that o
nitroglycerin

PRECAUTIONS As with other effective nitrites
some fall in blood pressure may occur with
large doses

Caution should be observed in administering
drug to patients with a history of recent cerebr
hemorrhage because of the vasodilation whic
occurs in the area Although therapy permits
more normal activity the patient should not be
allowed to misinterpret freedom from anginal
attacks as a signal to drop all restrictions

SIDE EFFECTS No serious side effects have
been reported In sublingual therapy a tingling
sensation (like that of nitroglycerin) may some
times be noted at the point of tablet contact w
the mucous membrane If objectionable this
be mitigated by placing the tablet in the bucca
pouch As with nitroglycerin or other effective
nitrites, temporary vascular headache may oc
during the first few days of therapy This can b
controlled by temporary dosage reduction in
order to allow adjustment of the cerebral hem
dynamics to the initial marked cerebral vasod
tion These headaches usually disappear with
one week of continuous therapy but may be m
mized by the administration of analgesics

Mild gastrointestinal disturbances occur occa
sionally with larger doses and may be controll
by reducing the dose temporarily

HOW SUPPLIED 10 mg chewable scored tab
bottle of 100 Also 5 10 and 15 mg oral/subling
scored tablets in bottles of 100 10 mg oral/
sublingual scored tablets also supplied in bottl
of 1,000

Also available Cardilate®-P brand Erythrityl
Tetranitrate with Phenobarbital* Tablets (Score

(*Warning may be habit forming)

Wellcome
Burroughs Wellcome C
Research Triangle Park
North Carolina 2770



"**Our sex life is nil...**" A problem of the first magnitude to many post infarct patients and their mates...patients are often reluctant to broach the subject: physicians may frequently overlook its implications. This new 16mm film combines candid patient interviews with discussions by Drs. Herman Hellerstein, Thomas Hackett, Albert Kattus, Richard Stein, Carroll Witten and Lenore Zohman. Film and related monograph comprise 2 AAFP credit hours. To arrange viewing, write Burroughs Wellcome Co., Educational Services Department, Research Triangle Park, N.C. 27709 or contact your B.W. Co.® representative.

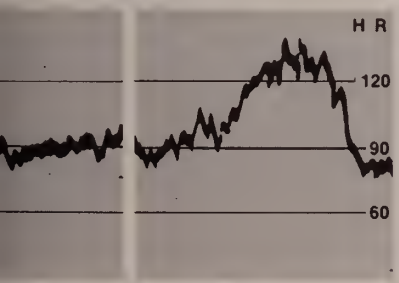
# Sex and the heart patient:

## A film every doctor should see.

**energy cost of sex to the rt is relatively modest.**

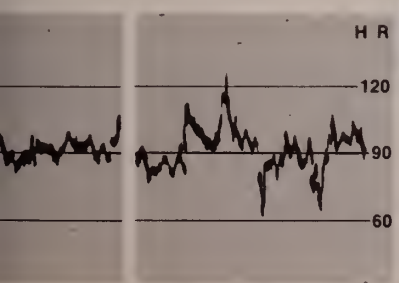
80% of post-coronary patients ultimately resume sexual activity out serious risk. Hellerstein and dman demonstrate that mean mal heart rate during orgasm spouse (as opposed to extra-al sex) in 14 post-infarct pa-s is lower than that during usual pational activity.

**esentations below of actual readings of an attorney, post llustrate the point:**




king in office
ut 90
ts/min)

B Confrontation in judge's chamber (about 125 beats/min)




orgasm sex
vity (about
eats/min)

D Peaks at orgasm (120 beats/min)



**Fear of pain greatest deterrent to post MI sex**

In the multitude of MI patients with angina, pain is due to diminished coronary reserve and increased myocardial oxygen demand, precipitated by sex, other excitement and improper exercise. Anginal pain, however, can be relieved, and its recurrence mitigated.

**Cardilate® (erythrityl tetranitrate) increases exercise tolerance.**

Cardilate relieves anginal pain and prevents its recurrence, thereby allowing increased activity.

Commencing to work in as little as 2 to 5 minutes, Cardilate protects against recurrence of angina for at least 2 hours.

Available in both sublingual and chewable forms, Cardilate is a versatile, convenient agent to help make the angina patient's life more livable.

# Cardilate®
## (erythrityl tetranitrate)

## *Editorial Comment*

# *Attacking the Cost Crisis*

"Physicians can and must play a major role in reducing or at least stabilizing health-care costs."

Those challenging words come from a leader in organized medicine at the state level—Richard J. Frey, M.D., chairman of the Council (or Board of Trustees) of the Minnesota State Medical Association.

He is also chairman of the Health Care Cost Commission sponsored by MSMA, the group to which those remarks were directed.

The commission, which held its first meeting in May, is conducting an 18-month study of rising health-care costs (with the help of a professor at the University of Minnesota's School of Public Health). It will issue "independent" recommendations that will go straight to the people without alteration.

MSMA is among the growing number of state medical societies that are eager to zero in on the cost problem, regardless of the complexities or possible outcome.

The commission's members include representatives not only from medicine, but also from civic affairs, industry, banking, insurance, state government, labor, and hospitals. A state senator member was appointed by Gov. Rudy Perpich, who strongly supports the commission's efforts.

In diversity of makeup as well as purpose, it thus resembles the AMA medical cost commission.

Doctor Frey, an internist, told the initial meeting in St. Paul:

"As an association, we could approach this situation in a variety of ways. We could, for example, say that the problem doesn't exist. Then again we could, as physicians, blame it on the hospitals, or government, or the health planners, the insurance industry, the public, or some other entity than ourselves.

"Then again we could say that physicians as a group are a very significant contributing factor to the question of costs. Although physician fees are a small part of the health-care dollar, as a group physicians serve as purchasers of medical and health care for their patients and as such are indeed a major factor in determining the extent of total health-care expenditures in this nation."

The commission's final report will include:

- A definition of the health-care delivery systems in the state.
- An identification of Minnesota and national forces creating increases in health-care costs.
- A review and evaluation of existing research on the causes of such increases.
- A review of Minnesota health-care systems outside the traditional fee-for-service system.
- Detailed recommendations for future programs that would contain costs while providing high-quality care.

The findings should be awaited with eagerness. And with a spirit of faith in what we in organized medicine can generate on our own.

**AMA**

*(Ed. note: ISMS has recently created a Task Force on Cost Containment. A series of provocative commentaries is planned for* IMJ. *These discussion topics will be open for review and comment by all members. Should any member have thoughts on this subject please submit them to the ISMS office.)*




**"I'm just a shadow of what I used to be."**

That is what depressed individuals may feel is the substance of their being. There is no pleasure, no joy — nothing grows — and in the cold shadow of depression their activities are inhibited, while initiative may be eroded or destroyed. The tragedy is that they can see that others are able to live on the brighter side but they, themselves, cannot reach it on their own.

Your experience in treating depression, and Tofranil-**PM** can help light the way.

# Tofranil-**PM**®
imipramine **pamoate**

Geigy

## Unsurpassed effectiveness among tricyclics in relieving symptoms of anxious depression.

Before prescribing Tofranil-PM, please review a summary of the prescribing information on the back of this page.

# Tofranil-**PM**®
imipramine **pamoate**

Geigy

As anxiety, agitation, sleep disturbances, and other depressive symptoms are relieved, mood and motivation may be markedly improved.

Patients are usually alert and capable of functioning at more normal levels of behavior.

Tofranil-PM encourages patient compliance because one capsule lasts from bedtime to bedtime.

Good results are usually seen at the starting dose of one 75-mg capsule h.s.

For many patients, dosage can be safely increased to 150 mg daily.

As with all tricyclics, sedation may occur. Please caution patients against driving or operating dangerous machinery.

Each capsule contains imipramine pamoate equivalent to 75, 100, 125 or 150 mg of imipramine hydrochloride.

**Tofranil-PM®**
**brand of imipramine pamoate**

**Indications:** For the relief of symptoms of depression. Endogenous depression is more likely to be alleviated than other depressive states.

**Contraindications:** The concomitant use of monoamine oxidase inhibiting compounds is contraindicated. Hyperpyretic crises or severe convulsive seizures may occur in patients receiving such combinations. The potentiation of adverse effects can be serious, or even fatal. When it is desired to substitute Tofranil-PM, brand of imipramine pamoate, in patients receiving a monoamine oxidase inhibitor, as long an interval should elapse as the clinical situation will allow, with a minimum of 14 days. Initial dosage should be low and increases should be gradual and cautiously prescribed. The drug is contraindicated during the acute recovery period after a myocardial infarction. Patients with a known hypersensitivity to this compound should not be given the drug. The possibility of cross-sensitivity to other dibenzazepine compounds should be kept in mind.

**Warnings:** *Usage in Pregnancy:* Safe use of imipramine during pregnancy and lactation has not been established; therefore, in administering the drug to pregnant patients, nursing mothers, or women of childbearing potential, the potential benefits must be weighed against the possible hazards. Animal reproduction studies have yielded inconclusive results. There have been clinical reports of congenital malformation associated with the use of this drug, but a causal relationship has not been confirmed.

Extreme caution should be used when this drug is given to:

—patients with cardiovascular disease because of the possibility of conduction defects, arrhythmias, myocardial infarction, strokes and tachycardia;
—patients with increased intraocular pressure, history of urinary retention, or history of narrow-angle glaucoma because of the drug's anticholinergic properties;
—hyperthyroid patients or those on thyroid medication because of the possibility of cardiovascular toxicity;
—patients with a history of seizure disorder because this drug has been shown to lower the seizure threshold;
—patients receiving guanethidine or similar agents since imipramine may block the pharmacologic effects of these drugs.

Since imipramine may impair the mental and/or physical abilities required for the performance of potentially hazardous tasks such as operating an automobile or machinery, the patient should be cautioned accordingly.

*Usage in Children:* Tofranil-PM, brand of imipramine pamoate, should not be used in children of any age because of the increased potential for acute overdosage due to the high unit potency (75 mg., 100 mg., 125 mg. and 150 mg.). Each capsule contains imipramine pamoate equivalent to 75 mg., 100 mg., 125 mg. or 150 mg. imipramine hydrochloride.

**Precautions:** It should be kept in mind that the possibility of suicide in seriously depressed patients is inherent in the illness and may persist until significant remission occurs. Such patients should be carefully supervised during the early phase of treatment with Tofranil-PM, brand of imipramine pamoate, and may require hospitalization. Prescriptions should be written for the smallest amount feasible.

Hypomanic or manic episodes may occur, particularly in patients with cyclic disorders. Such reactions may necessitate discontinuation of the drug. If needed, Tofranil-PM, brand of imipramine pamoate, may be resumed in lower dosage when these episodes are relieved. Administration of a tranquilizer may be useful in controlling such episodes.

Prior to elective surgery, imipramine should be discontinued for as long as the clinical situation will allow.

An activation of the psychosis may occasionally be observed in schizophrenic patients and may require reduction of dosage and the addition of a phenothiazine.

In occasional susceptible patients or in those receiving anticholinergic drugs (including antiparkinsonism agents) in addition, the atropine-like effects may become more pronounced (e.g., paralytic ileus). Close supervision and careful adjustment of dosage is required when this drug is administered concomitantly with anticholinergic or sympathomimetic drugs.

Avoid the use of preparations, such as decongestants and local anesthetics, which contain any sympathomimetic amine (e.g., adrenalin, noradrenalin), since it has been reported that tricyclic antidepressants can potentiate the effects of catecholamines.

Patients should be warned that the concomitant use of alcoholic beverages may be associated with exaggerated effects.

Both elevation and lowering of blood sugar levels have been reported.

Concurrent administration of imipramine with electroshock therapy may increase the hazards; such treatment should be limited to those patients for whom it is essential, since there is limited clinical experience.

**Adverse Reactions:** Note: Although the listing which follows includes a few adverse reactions which have not been reported with this specific drug, the pharmacological similarities among the tricyclic antidepressant drugs require that each of the reactions be considered when imipramine is administered.

*Cardiovascular:* Hypotension, hypertension, tachycardia, palpitation, myocardial infarction, arrhythmias, heart block, stroke, falls.

*Psychiatric:* Confusional states (especially in the elderly) with hallucinations, disorientation, delusions; anxiety, restlessness, agitation; insomnia and nightmares; hypomania; exacerbation of psychosis.

*Neurological:* Numbness, tingling, paresthesias of extremities; incoordination, ataxia, tremors; peripheral neuropathy; extrapyramidal symptoms; seizures, alterations in EEG patterns; tinnitus.

*Anticholinergic:* Dry mouth, and, rarely, associated sublingual adenitis; blurred vision, disturbances of accommodation, mydriasis; constipation, paralytic ileus; urinary retention, delayed micturition, dilation of the urinary tract.

*Allergic:* Skin rash, petechiae, urticaria, itching, photosensitization (avoid excessive exposure to sunlight); edema (general or of face and tongue); drug fever; cross-sensitivity with desipramine.

*Hematologic:* Bone marrow depression including agranulocytosis; eosinophilia; purpura; thrombocytopenia. Leukocyte and differential counts should be performed in any patient who develops fever and sore throat during therapy; the drug should be discontinued if there is evidence of pathological neutrophil depression.

*Gastrointestinal:* Nausea and vomiting, anorexia, epigastric distress, diarrhea; peculiar taste, stomatitis, abdominal cramps, black tongue.

*Endocrine:* Gynecomastia in the male; breast enlargement and galactorrhea in the female; increased or decreased libido, impotence; testicular swelling; elevation or depression of blood sugar levels.

*Other:* Jaundice (simulating obstructive); altered liver function; weight gain or loss; perspiration; flushing; urinary frequency; drowsiness, dizziness, weakness and fatigue; headache; parotid swelling; alopecia.

*Withdrawal Symptoms:* Though not indicative of addiction abrupt cessation of treatment after prolonged therapy may produce nausea, headache and malaise.

**Dosage and Administration:** In adult outpatients, therapy should be initiated on a once-a-day basis with 75 mg./day. This may be increased to 150 mg./day which is the dose level which usually obtains optimum response. If necessary, dosage may be increased to 200 mg./day. Dosage should be modified as necessary by clinical response and any evidence of intolerance. Daily dosage may be given at bedtime, or in some patients in divided daily doses.

Hospitalized patients should be started on a once-a-day basis with 100-150 mg./day and may be increased to 200 mg./day. Dosage should be increased to 250-300 mg./day if there is no response after two weeks.

Following remission, maintenance medication may be required for a longer period of time at the lowest dose that will maintain remission. The usual adult maintenance dosage is 75-150 mg./day on a once-a-day basis, preferably at bedtime.

In adolescent and geriatric patients, capsules of Tofranil-PM, brand of imipramine pamoate, may be used when total daily dosage is established at 75 mg. or higher. It is generally unnecessary to exceed 100 mg./day in these patients. This dosage may be given once a day at bedtime or, if needed, in divided daily doses.

**How Supplied:** Tofranil-PM, brand of imipramine pamoate. Capsules of 75, 100, 125 and 150 mg. (Each capsule contains imipramine pamoate equivalent to 75, 100, 125 or 150 mg. of imipramine hydrochloride.)
(B) 98-146-840-A(9/75) 667120

**For complete details, including dosage and administration, please refer to the full prescribing information.**

GEIGY Pharmaceuticals
Division of CIBA-GEIGY Corporation
Ardsley, New York 10502

Printed in U.S.A. (10-77) TO 12889



# new pharmaceutical specialties

By Paul Dehaen

For detailed information regarding indications, dosage, contraindications and adverse reactions, refer to the manufacturer's package insert or brochure.

**New Single Drugs**—Drugs not previously known, including new salts.

**Duplicate Single Drugs**—Drugs marketed by more than one manufacturer.

**Combination Products**—Drugs consisting of two or more active ingredients.

**New Dosage Forms**—Of a previously introduced product.

**The following new drugs have been marketed:**

## NEW SINGLE DRUGS

**TAGAMET** — Antihistamine ($H_2$-Receptor Antagonist) Rx

| | |
|---|---|
| Manufacturer: | Smith Kline French Laboratories |
| Indications: | Short-term treatment of duodenal ulcer and Pathologic hypersecretory conditions |
| Dosage: | Oral; 300 mg q.i.d.<br>Parenteral; 300 mg every six hours, i.v. |
| Supplied: | Tablets, 300 mg<br>Ampules, 2 ml/300 mg |

## DUPLICATE SINGLE DRUGS

**DISALCID** — Anti-inflammatory Agent Rx

| | |
|---|---|
| Manufacturer: | Riker Laboratories, Inc. |
| Nonproprietary Name: | Salsalate |
| Indications: | Symptoms of rheumatoid arthritis, osteoarthritis and other rheumatic conditions |
| Contraindications: | Patients allergic to salicylates |
| Dosage: | Two tablets t.i.d. |
| Supplied: | Tablets, 500 mg |

**WEHDRYL-5-Inj** — Antihistamine Rx

| | |
|---|---|
| Manufacturer: | W. E. Hauck, Inc. |
| Nonproprietary Name: | Diphenhydramine HCl |
| Indications: | Amelioration and prevention of allergic reactions when oral use is impracticable |
| Contraindications: | Those common with antihistamines |
| Dosage: | Adults: 10 to 50 mg i.v. or deep i.m.<br>Children; 5 mg/kg 24 hours |
| Supplied: | Multi-dose vial |

## COMBINATION PRODUCTS

**CIRCANOL** — Rx

| | |
|---|---|
| Manufacturer: | Riker Laboratories, Inc. |
| Composition: | Dihydroergocornine )Mesylate<br>Dihydroergocristine )167 mg<br>Dihydroergocryptine )each |
| Indications: | Dizziness and confusion of the elderly |
| Dosage: | Two sublingual tablets t.i.d. |
| Supplied: | Tablets; 0.5 mg |

**NUCOFORD Syrup** — Cough Preparation Rx

| | |
|---|---|
| Manufacturer: | Beecham Laboratories |
| Composition: | Codeine Phosphate 20 mg<br>Pseudoephedrine 60 mg |
| Indications: | Symptomatic relief of coughing and congestion associated with upper respiratory infections |
| Caution: | Do not use in persistent cough |
| Dosage: | Adults; 1 teaspoonful every 4 to 6 hr<br>Children; see package insert |
| Supplied: | Syrup, 1 pint |

**TYLOS** — Narcotic Analgesic Rx

| | |
|---|---|
| Manufacturer: | McNeil Laboratories, Inc. |
| Composition: | Oxycodone terephthalate 4.5 mg<br>Acetaminophen 500 mg |
| Indications: | Moderate to severe pain |
| Caution: | May be habit forming |
| Dosage: | One capsules every six hours, adjust to response of patient |
| Supplied: | Capsules |

**VI-DAYLIN/F ADC+IRON Drops** — Vitamin-Mineral Combination Rx

| | |
|---|---|
| Manufacturer: | Ross Laboratories |
| Composition: | Vitamin A 1500 IU<br>Vitamin D 400 IU<br>Vitamin C 35 mg<br>Iron 10 mg<br>Fluoride 0.5 mg |
| Indications: | Prevention of dental caries in infants and children and prophylaxis of iron and vitamin deficiencies |
| Dosage: | One dropperful daily |
| Supplied: | Dropper bottle |

**VI-DAYLIN/F+IRON Drops** — Vitamin-Mineral Combination Rx

| | |
|---|---|
| Manufacturer: | Ross Laboratories |
| Composition: | Vitamin A,D,E,C,$B_1$,$B_2$<br>Niacin 8 mg<br>Iron 10 mg<br>Fluoride 0.5 mg |
| Indications: | Prevention of dental caries in infants and children and prophylaxis of iron vitamin deficiencies |
| Dosage: | One dropperful |
| Supplied: | Dropper bottle |

# Kefzol® I.M./I.V.

## cefazolin sodium

Ampoules, equivalent to 500 mg., 1 Gm.,
and 10 Gm. of cefazolin




Lilly

*Additional information available to the profession on request.*
Eli Lilly and Company
Indianapolis, Indiana 46206

700773

IMJ
Illinois Medical Journal
Vol. 153, No. 1, January, 1978

# Temporary Cardiac Pacing in a Community Practice

By Donald M. Coder, M.D./Highland Park

*Temporary cardiac pacing in a community practice was previously accomplished via a venous cut-down. This technique was found to be unsatisfactory. Percutaneous insertion into a central vein was employed in a consecutive series of 42 cases, 40 of which were in the cardiac care unit. A disposable, "semi-floating," bipolar catheter under fluoroscopic control was employed. The right internal jugular vein was used 39 times and the right subclavian vein 3 times. The most frequent complication was inadequate sensing, which occurred in 11% of the cases. This was easily corrected every time by conversion to a unipolar system with a technique described below. The technique was rapid, safe and obviated the need for a venous cut-down. In all but one case, the electrode was stable in position.*

Temporary transvenous cardiac pacing is an increasingly important therapeutic modality in the acute care of cardiac disorders. Since electrical cardiac pacing was first introduced to clinical use in the 1950's, the indications have expanded from arrest and complete heart block to include conductive disorders without bradycardia and certain tachyarrhythmias.[1,2] Even in the absence of a diagnostic cardiac catheterization program, community hospitals providing care for acute cardiac disorders must be prepared to institute temporary cardiac pacing in a wide variety of conditions. Ideally, the procedure should be performed in the cardiac care unit, the lead should be stable in position, placement should be rapid when necessary, and the complication rate should be low.

In 1970 the author first began placement of temporary transvenous cardiac pacemakers in our 260 bed community hospital. The procedures were performed in the cardiac care unit utilizing

DONALD M. CODER, M.D., is o clinical assistont professor of surgery ot the University of Illinois Abrohom Lincoln School af Medicine. A fellow of the American Boord of Surgery, Doctor Coder is olso ottending staff at Hines Veteran's Administrotion Haspitol.

fluoroscopic control and a radiolucent bed. A variety of pacing catheters were employed, primarily standard, relatively stiff, woven, bipolar electrodes size 5 or 6 French, or size 10 French with guide wires. A cut-down on peripheral vein was standard.

In 1972 we reviewed our experience and were dissatisfied with the techniques in use. The time required for a venous cut-down, frequent difficulty in advancing the electrode into the right ventricle, and the mechanical instability of the electrodes were cited. We elected to evaluate the simpler technique of inserting a pacing catheter in a central vein through a cannula. This enabled utilization of existing skills gained with placement of central venous pressure catheters. We selected a size 4 French "semi-floating" bipolar catheter which was stiff enough for good control, with a permanent curve at the pacing end for ease in manipulation.* It was supplied as a pre-packaged, sterile, disposable unit which included a 2¼ inch introducing cannula. Initial experience with this procedure was satisfactory and we continue to use it.

**Procedures**

All but two of the 42 procedures were performed in the cardiac care unit. One was performed in the X-ray department because both portable fluoroscopes were inoperable and one was performed in the operating room before placement of a myocardial lead. The patient was placed on a radiolucent bed and a C-arm portable fluoroscope was placed over the precordium with the unit chassis to the patient's left. An intravenous infusion was started and lidocaine prepared for immediate use if dangerous arrhythmias occurred. Extremity leads were connected to an oscilloscope and a recording ECG.

During the procedure, the patient was flat on the bed, head turned to the left. The operator wore sterile gloves. Caps, masks, and sterile gown were not used but were kept at hand in case a venous cut-down became necessary. A venous cut-down tray was always opened to provide sterile towels, gauze sponges, syringes and needles, scissors, and needle holder. The skin was painted with iodophor and draped with 2 or 3 sterile towels. One sterile towel was placed on the fluoroscope so the operator could manipulate it during the procedure. The right subclavian vein was employed 3 times and the right internal jugular vein 39. The standard infraclavicular approach was used for subclavian venipuncture.

**Internal Jugular Venipuncture**

The operator stood at the head of the bed. The skin was infiltrated with 1% plain lidocaine about 2 centimeters cephalad to the right clavicle and just at or slightly medial to the medial border of the sternocleidomastoid muscle's clavicular head. This is the so-called central route as described by Defaque,[3] Daily,[4] and others, except that we usually found the vein closer to the sternocleidomastoid muscle's clavicular head. This attachment is usually palpable when it is not visible. The introducing cannula with the external plastic cannula was attached to a 2 or 5 milliliter plastic syringe which contained a small amount of lidocaine, and the needle was inserted through the skin and directly caudally. It was kept parallel to the long axis of the body and at about a 30 degree angle to the horizontal. A small amount of fluid was injected to flush the needle after skin puncture. The needle was advanced with a slight negative pressure on the syringe until the vein was entered. Then the plastic cannula was advanced, needle withdrawn, and pacing catheter promptly inserted and advanced with fluoroscopic guidance to the stable position in the right ventricle's apex. If the internal jugular vein was not entered the needle was withdrawn and redirected more laterally. Arterial bleeding, which probably arose from the innominate artery, was rarely encountered with needle advancement. When arterial bleeding did occur the needle was removed and pressure was applied for 5 minutes. The needle was then reinserted, usually more laterally.

The plastic needle was left in the vein until manipulation of the lead was completed. After the electrode was satisfactorily wedged, pacing and sensing thresholds were measured using an external generator. Stability was evaluated when possible by having the patient breathe deeply and cough while under fluoroscopic observation. A pacing threshold of 1.0 milliampere or less was sought, and usually readily achieved. The electrode was tied in place with one silk suture size 2-0 placed through the skin at the site of skin entry. Iodophor ointment was applied and a sterile occlusive dressing taped in place. The generator was usually set at 5 milliamperes or at least twice the pacing threshold and sensing control was set in full demand position.

If sensing with the bipolar electrode was unsatisfactory, an 18 gauge needle was inserted sub-

cutaneously near the catheter skin entry site and sutured in place with a silk suture size 2-0. An indifferent electrode cable** was attached to the needle and the other end connected through the connecting cable to the generator's positive pole. The negative pole of the generator remained attached to the pacing catheter's distal electrode and the wire leading to its proximal electrode was covered with tape. Thus the bipolar system was converted to a unipolar system.

Every 48 hours the skin at the catheter entry site was cleaned with iodophor as fresh iodophor ointment and sterile dressings were applied. The patient was kept flat on the back for 48 hours allowing head of the bed elevation to 45 degrees. Graduated activity was permitted as the underlying cardiac process allowed. Sensing and pacing thresholds were measured daily for the first week and every several days thereafter.

## Results

This insertion method for a temporary cardiac pacing catheter was employed 42 consecutive times in 41 patients, 22 males and 19 females. Age ranged from 37 to 99 years with a mean age of 70. The percutaneous approach provided satisfactory access to the central vein in all 42 cases, obviating the need for a surgical venous cut-down. Indications for temporary pacing are summarized in Table I.

**Table 1**

| Indications | With Acute Infarction | Without Acute Infarction |
|---|---|---|
| Complete Heart Block | 11 | 12 |
| Sick Sinus Syndrome | | 6 |
| Second Degree Heart Block | 2 | 2 |
| Failure of Permanent Pacemaker | | 2 |
| Other | 4 | 3 |

The electrode was in place from 1 to 42 days with a mean of 10.7 days, and the lead was utilized for pacing a mean of 8.5 days. A permanent pacemaker was inserted before removal of the temporary catheter in 16 patients.

In one patient the electrode could not be advanced into the right atrium because of a mechanical obstruction in the superior vena cava. Access via the inferior vena cava was not pursued because the transient, apparently drug-induced bradycardia, resolved spontaneously.

Temporary transvenous pacing was unsatisfactory in two patients who were managed with placement of permanent myocardial electrodes via a limited left thoracotomy. In one of these, a patient with complete heart block, the electrode caused painful diaphragmatic contractions in spite of repeated repositioning. The other patient, also with complete heart block, had a massively dilated heart which was completely refractory to endocardial stimulation.

## Few Procedural Complications

There were no deaths attributable to the procedure, no pneumothorax or hemothorax, no known cardiac perforation, no infection, and no ventricular fibrillation during manipulation of the electrode. Rarely was a bolus of lidocaine given intravenously for frequent premature ventricular contractions. We were not aware of any complications arising from accidental entry of an artery by the introducing cannula, and there were no hematomas in this series.

## Course After Insertion

Six patients had the electrode in place for 24 hours or less, and three of these died from uncontrollable arrhythmias. Four of the other 36 patients demonstrated unsatisfactory sensing despite satisfactory driving thresholds, and all were converted to a unipolar system. Following conversion, all four showed excellent sensing function. Only one electrode became displaced. This occurred on the sixth day and repositioning under fluoroscopic control was necessary. The electrode was re-positioned in one other patient on the second day because of unsatisfactory position on the chest X-ray, although no displacement was apparent. Because of poor driving without apparent displacement, two other electrodes were advanced without fluoroscopic control and a satisfactory driving threshold was restored. Thus, a total of 4 electrodes or 11% of those in place 24 hours or more were re-manipulated.

## Discussion

Satisfactory experience with percutaneous access to the internal jugular vein for placement of infusion catheters lead us to employ this route for placement of temporary cardiac pacing electrodes. Although we have been unable to enter the internal jugular vein percutaneously in some shock patients, which then necessitated the use of a cut-down on a peripheral vein, we did not

fail to gain access to a central vein percutaneously in this series of 42 temporary pacing lead placements. Apparently the patient population in need of a cardiac pacemaker has better venous distention, which facilitates percutaneous entry of the central veins. However, we always kept a cut-down tray open and were prepared to expose a vein if necessary. Occasionally we had to advance the needle several times before entering the internal jugular vein, usually because the initial entry site was too medial. It appears that percutaneous cannulation of the internal jugular vein is more reliable and carries a lower risk than cannulation of the subclavian vein.[5] Widman, *et al.*, reported a series of 148 cases of temporary pacing catheter percutaneous placement in an internal jugular vein. They failed to enter an internal jugular vein percutaneously in only 8% of these.[5]

The 4 French disposable pacing catheter which we used in this series proved to be mechanically stable once it was wedged properly. The displacement rate was 3%, or 1 out of 36 cases in which it was left in place for several days. An additional 3 electrodes were remanipulated although chest X-rays did not indicate displacement. The bipolar electrode which we employed had an 11% incidence of improper sensing which was apparently not due to poor positioning. In all 4 of these cases, conversion to a unipolar system corrected the sensing problem. Perhaps sensing would have been more reliable if there were a greater distance between the tip and ring electrodes. The catheter was rigid enough for good control, and the bend at the pacing end facilitated passage through the tricuspid valve.

We have been pleased with the technique of placing the electrode with the patient in the cardiac care unit on a radiolucent bed. Although it necessitates moving the patient onto a special bed, it does obviate the need to transport the patient to the X-ray department and it permits the use of the equipment always at hand in the special unit. We have had no experience with placement of an electrode with ECG guidance, and we find that achieving a low threshold with good catheter stability, even with a good fluoroscope image, is sometimes difficult.

Nine of the patients in this series had placement of a permanent transvenous pacemaker before removal of the temporary electrode was possible, and we experienced no difficulty in preserving a sterile field with the temporary electrode in the supraclavicular position. We employed the right internal jugular vein for permanent electrode placement in three of these cases.

Patient acceptance of catheter placement in the neck was excellent because it was unnecessary to limit the use of the extremities. This was particularly important when temporary pacing was necessary for many days or even weeks. ◄

## References


1. Zoll, P. M.: "Resuscitation of the Heart in Ventricular Standstill by External Electric Stimulation," *N. Eng. J. Med.*, 247:768-171, 1952.
2. Kitchen, III J. G., Kastor, J. A.: "Pacing in Acute Myocardial Infarction-Indications, Methods, Hazards, and Results," *Cardiov. Clin.*, 7:219-243, 1975.
3. Defalque, R. J.: "Percutaneous Catheterization of the Internal Jugular Vein," *Anesth. Analg.*, 53:116-121, 1974.
4. Daily, P. O., Griepp, R. B., Shumway, N. E.: "Percutaneous Internal Jugular Vein Cannulation," *Arch. Surg.*, 101:534-536, 1970.
5. Widmann, W. L., Mangiola, S., Thomas, L., Venezia, J.: "Percutaneous Cannulation of the Internal Jugular Vein for Temporary Endocardial Pacing," *Cathet. Cardiov. Diagn.*, 1:233-245, 1975.


*Cordis 370-112, Cordis Corp., Miami, Fla.

**Medtronic indifferent electrode cable Model 5451, Medtronic, Inc., Minneapolis, Minn.


**COOK COUNTY**

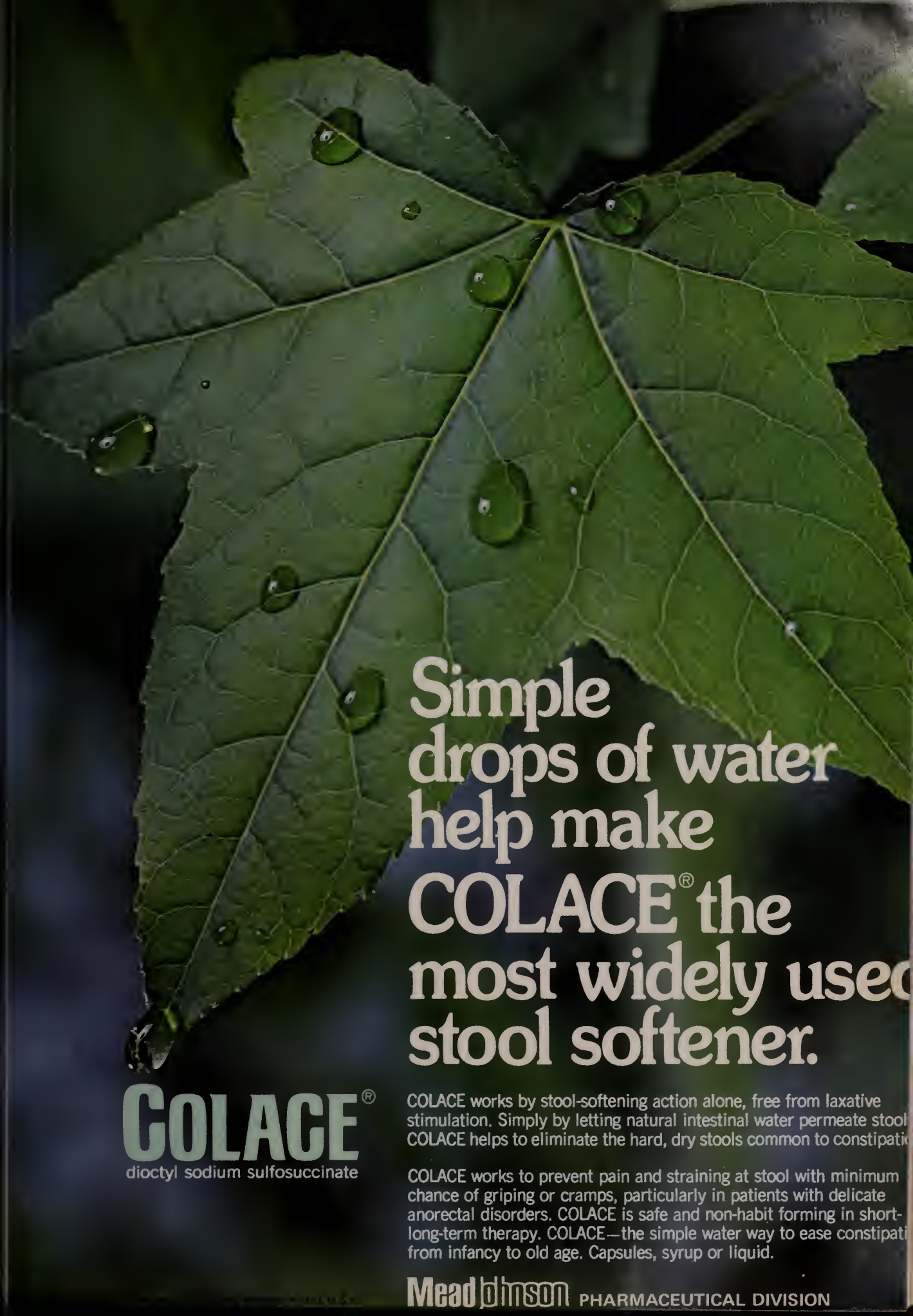
**Graduate School of Medicine**

CONTINUING EDUCATION COURSES
STARTING DATES—1978

RECENT ADVANCES IN NEUROLOGY, 5 days, January 23
SPECIALTY REVIEW NEUROLOGICAL SURGERY, February 3
SPECIALTY REVIEW THORACIC SURGERY, February 13
NEUROPATHOLOGY, One Week, February 27
NEUROLOGY, PART I, BASIC, March 6
BASIC INTERNAL MEDICINE, 5 days, March 6
SPECIALTY REVIEW SURGERY, PART II, March 6
DIAGNOSIS & MANAGEMENT OF PROBLEMS IN GYNECOLOGY, March 6
BASIC EKG, 5 days, March 27
EKG FOR ANESTHESIOLOGISTS, 5 days, March 27
ADVANCED EKG, Two and a half days, April 3
BASIC PSYCHIATRY, 5 days, April 3
DIAGNOSTIC RADIOLOGY, 5 days, April 3
SPECIALTY REVIEW PEDIATRICS, 5½ days, April 3
SPECIALTY REVIEW UROLOGY, 5 days, April 10
BASIC SEMINAR & WORKSHOP IN ECHOCARDIOGRAPHY, April 19
STATE & NAT'L. BD. REV. BASIC, April 30, CLINICAL, May 8

*Information concerning numerous other continuation courses available upon request.*

**Address:**
**REGISTRAR, 707 South Wood Street,**
**Chicago, Ill. 60612**



# Simple drops of water help make COLACE® the most widely used stool softener.

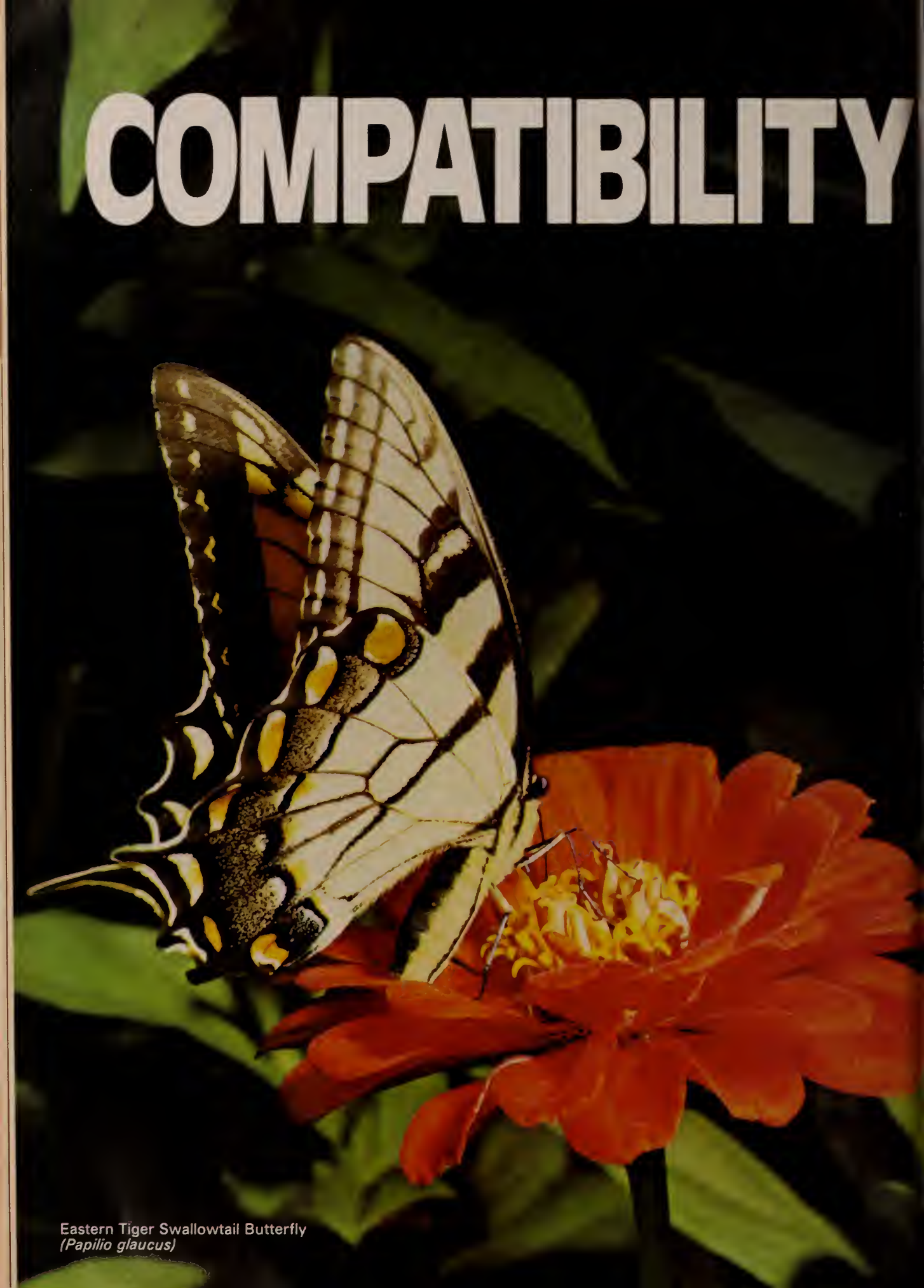
**COLACE®**
dioctyl sodium sulfosuccinate

COLACE works by stool-softening action alone, free from laxative stimulation. Simply by letting natural intestinal water permeate stool COLACE helps to eliminate the hard, dry stools common to constipati

COLACE works to prevent pain and straining at stool with minimum chance of griping or cramps, particularly in patients with delicate anorectal disorders. COLACE is safe and non-habit forming in short- long-term therapy. COLACE—the simple water way to ease constipati from infancy to old age. Capsules, syrup or liquid.

Mead Johnson PHARMACEUTICAL DIVISION

# COMPATIBILITY



Eastern Tiger Swallowtail Butterfly
*(Papilio glaucus)*

# Does it influence your choice of a peripheral/cerebral vasodilator*?

## Vasodilan–compatible with coexisting diseases (e.g., glaucoma, diabetes)

Vasodilan has not been reported to affect the course of coexisting disease; it has not been reported to affect blood sugar levels or to raise intraocular pressure.

## Vasodilan–compatible with concomitant therapy

Vasodilan has not been reported to affect the treatment of coexisting disease; it is compatible with such drugs as hypoglycemics and miotics.

## Vasodilan–compatible with your total regimen for vascular insufficiency

Vasodilan can be a valuable adjunct in planning a total therapeutic program for vascular insufficiency.

*Indications: Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows:
Possibly Effective:
1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.
Final classification of the less-than-effective indications requires further investigation.

**Composition:** Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg.
Vasodilan injection, isoxsuprine HCl, 5 mg., per ml.

**Dosage and Administration:** Oral: 10 to 20 mg., three or four times daily.
Intramuscular: 5 to 10 mg.(1 or 2 ml.) two or three times daily. Intramuscular administration may be used initially in severe or acute conditions.

**Contraindications and Cautions:** There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

Parenteral administration is not recommended in the presence of hypotension or tachycardia.

Intravenous administration should not be given because of increased likelihood of side effects.

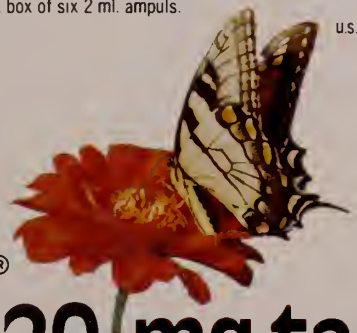
**Adverse Reactions:** On rare occasions oral administration of the drug has been associated in time with the occurrence of hypotension, tachycardia, nausea, vomiting, dizziness, abdominal distress, and severe rash. If rash appears the drug should be discontinued.

Although available evidence suggests a temporal association of these reactions with isoxsuprine, a causal relationship can be neither confirmed nor refuted.

Administration of single dose of 10 mg. intramuscularly may result in hypotension and tachycardia. These symptoms are more pronounced in higher doses. For these reasons single intramuscular doses exceeding 10 mg. are not recommended. Repeated administration of 5 to 10 mg. intramuscularly at suitable intervals may be employed.

**Supplied:** Tablets, 10 mg., bottles of 100, 1000, 5000 and Unit Dose; Tablets, 20 mg., bottles of 100, 500, 1000, 5000 and Unit Dose; Injection, 10 mg. per 2 ml. ampul, box of six 2 ml. ampuls.

U.S. Pat. No. 3,056,836



# VASODILAN® 20-mg tablets

## (ISOXSUPRINE HCl)

**20 mg q.i.d. recommended dosage**

Mead Johnson
PHARMACEUTICAL DIVISION

© 1978 MEAD JOHNSON & COMPANY • EVANSVILLE, INDIANA 47721 U.S.A. MJL 7-4237R

# This asthmatic isn't worried about his next breath...



## he's active
## he's effectively maintained on

# QUIBRON®

Each capsule or tablespoon (15 ml) elixir contains theophylline (anhydrous) 150 mg and glyceryl guaiacolate (guaifenesin) 90 mg. Elixir: alcohol 15%

- high theophylline for effective around-the-clock therapy
- 100% free theophylline
- individualized theophylline dosage schedule

**Indications:** For the symptomatic treatment of bronchospostic conditions such as bronchial asthma, asthmatic bronchitis, chronic bronchitis, and pulmonary emphysema.
**Dosage:** Initial: Adults: 1-2 capsules or 1-2 tablespoonfuls elixir every 6-8 hours, children 8-12: 1 tablespoonful or one capsule every 6-8 hours and children under 8: 3 to 5 mg theophylline/kg body weight every 6-8 hours. Theophylline dosage may be cautiously increased to 2000 mg/24 hr in adults or 7 mg/kg in children; monitoring of serum theophylline levels at higher dosages is recommended.
**Precautions:** Do not administer more frequently than every 6 hours, or within 12 hours after rectal dose of any preparation containing theophylline or aminophylline. Do not give other xanthine derivatives concurrently. Use in case of pregnancy only when clearly needed.
**Adverse Reactions:** Theophylline may exert some stimulating effect on the central nervous system. Its administration may cause local irritation of the gastric mucosa, with possible gastric discomfort, nausea and vomiting. The frequency of adverse reactions is related to the serum theophylline level and are not usually a problem at serum theophylline levels below 20μg/ml.
**How Supplied:** Capsules in bottles of 100 and 1000 and unit-dose packs of 100; Elixir in bottles of 1 pint and 1 gallon.

Mead Johnson
PHARMACEUTICAL DIVISION

© 1978 Mead Johnson & Company • Evansville, Indiana 47721 U.S.A MJL 6-4220R

# Radiology In Malpractice Cases

By William A. Thomas, Ph.D., J.D./Chicago

*Radiology was a central issue in 35 of the 480 medical malpractice cases filed in Cook County, Illinois, in 1973. By January 1977, parties had settled 24 of them, judges had dismissed nine, one remained in pretrial stages, and only one had been tried. Alleged failure of physicians to make proper use of radiologic services accounted for nearly all of these lawsuits.*

The number of diagnostic radiologic examinations increases annually due to advances in their perceived usefulness, the greater number of patients being examined, and the current medicolegal situation that promotes defensive medicine. The practice of defensive medicine encourages physicians to request more radiographs than necessary for medical purposes in anticipation of a possible need to defend their actions or inactions.[1,2] For example, Bell and Loop reported that as many as 34% of skull radiographs were taken primarily for medicolegal reasons.[3]

The Committee on Efficacy Studies of the American College of Radiology is conducting a long-term study of diagnostic radiology. The main objective is to assess the information content of radiographs from the viewpoints of referring physicians. From the beginning of this project, committee members expressed interest in the prevalence of medical malpractice lawsuits that involve diagnostic radiology.

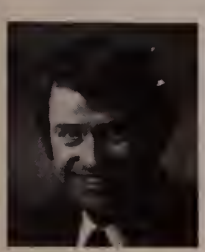
To obtain preliminary information, we reviewed the 480 medical malpractice cases filed in Cook County, Illinois, in 1973. Of these, 35 (about 7%) directly concerned radiology. Of course, radiographs will be presented as evidence in a high percentage of the other cases that come to trial. These 35 cases involved a total of 98 defendants (Table 1). The medical specialties listed in Table 1 are as designated in the court records, with the exception of radiologists. Eleven were cited in the records, but only nine were certified by the American Board of Radiology. The other two M.D.'s are classified here as physicians. Two cases concerning dental radiographs are not included in this tabulation.

## Survey of Claims

As of January 1977, only one of the 35 cases has been tried and one is still in pretrial proceedings, while 24 have been settled by the parties and nine have been dismissed by a judge for procedural reasons or with consent of both parties (Table 2). The jury in the case that was tried awarded a verdict for the plaintiff against an orthopedic surgeon who did not ascertain

**Table 1**
**Characteristics of Defendants in 35 Malpractice Cases Involving Radiology**

| | |
|---|---|
| Equipment manufacturer | 1 |
| Podiatrist | 4 |
| Radiologist | 9 |
| Unstated professional status | 13 |
| Surgeon | 18 |
| Hospital or clinic | 24 |
| Physician | 29 |
| Total | 98 |



WILLIAM A. THOMAS, Ph.D., J.D., is a research attorney with the American Bar Foundation in Chicago, where he is responsible for projects dealing with the interactions of law, science, and technology. He also serves on advisory panels for the National Academy of Sciences and the U.S. Congress' Office of Technology Assessment.

with radiographs whether a broken leg was aligned properly after setting. In the case not yet tried plaintiff charged that a surgeon failed to diagnose correctly a poorly set fracture that was evident on radiographs. This case still might be settled or dismissed.

The case involving radiation therapy claimed excessive dosages due to defective equipment, failure to keep adequate records, and use of inexperienced personnel. The patient suffered chronic ulceration following a radical mastectomy and the therapy. The parties settled out of court for a substantial amount.

Four of the nine certified radiologists were defendants in the case that alleged malpractice in cobalt and X-ray treatment. Certified radiologists also were included as defendants in cases that claimed (a) injury to an arm while being positioned for a radiograph, (b) an allergic reaction after an intravenous pyelogram examination, (c) a foot condition improperly diagnosed as hammer toe, (d) an unnecessary shrinkage of tendons in hand due to improper diagnosis from radiographs, (e) an inadequately treated wrist fracture, and (f) a fractured leg and foot diagnosed as a sprain.

Cases classified as "improper interpretation of radiographs" included assertions of incorrect diagnoses, such as not discovering fractures, and failure to see evidence in radiographs, such as lung infection.

Examples of cases in the category of "insufficient number of radiographs" are failure to obtain radiographs of a patient with pneumonia, a patient with multiple fractures, a patient with spinal irregularities, and a patient with a broken jaw that was treated as a toothache. Others alleged treatment for intoxication rather than a fractured skull and treatment of a gunshot wound as if the bullet had exited when in fact it had not.

### Burden of Proof

To succeed in a malpractice case, of course, it is necessary to do more than claim malpractice. The plaintiff must prove that (a) the physician had a duty to conform to a standard of care in treating the patient, (b) the physician failed to satisfy that standard of care as judged by prevailing medical standards, (c) the patient suffered an injury or adverse effect, and (d) the injury or adverse effect resulted from the physician's conduct. The key point in controversy often is what constitutes the prevailing standard of care. An attorney who knew that a radiologist either requested or interpreted the radiographs probably would mention this in the complaint because a radiologist would probably be held to a higher standard of care in interpreting them than would a referring physician.

By the very nature of initial complaints, many of the charges were vague because the attorneys did not then have access to the medical records of their clients. Even in cases with rather well-developed records, the allegations are not always clear. This lack of specificity, which often suggests a weak case, no doubt accounts for settlement or dismissal in a large number of cases.

**Table 2**

**Disposition of 35 Medical Malpractice Cases Filed in Cook County in 1973 that Directly Involved Radiology**

| General Allegation by Plaintiff | Number of Cases | Disposition | | | |
|---|---|---|---|---|---|
| | | Dismissed | Settled | Pretrial | Trial |
| Excessive doses during radiotherapy | 1 | - | 1 | - | - |
| Arm injured while positioning it | 1 | - | 1 | - | - |
| Allergic reaction during intravenous pyelogram | 1 | - | 1 | - | - |
| Improper interpretation and insufficient number of radiographs | 2 | 1 | 1 | - | - |
| Improper interpretation of radiographs | 12 | 2 | 9 | 1 | - |
| Insufficient number of radiographs | 18 | 6 | 11 | - | 1 |
| Totals | 35 | 9 | 24 | 1 | 1 |

Continuances agreed to by attorneys for both sides, extensions granted by the court to obtain more evidence by either side, and crowded court dockets, result in lengthy pretrial periods. Multiple defendants in complex cases further complicate these proceedings.

Results of this survey certainly are not conclusive but, if one assumes Cook County in 1973 to be representative, it appears that radiology becomes involved primarily because of alleged physician failure to use available radiologic services properly. The results might be different in less urbanized areas, where these services might not be as readily available. These cases do not permit any conclusions about the extent to which the involved physicians did practice defensive medicine. Some arguments in favor of defensive medicine are valid,[4] and the term does not deserve a completely negative connotation.

It is uncertain whether results from Cook County for additional years would justify the expense of obtaining them, but those presented here should be helpful to others who might be planning similar work, perhaps in conjunction with establishing guidelines for Health Maintenance Organizations or for Professional Standards Review Organizations.[5] ◄

### References


1. Potchen, E. J., Editor: "Study on the Use of Diagnostic Radiology," CURRENT CONCEPTS IN RADIOLOGY, Vol. 2:18-30, 1975.
2. Editorial Board and Staff: "The Medical Malpractice Threat: A Study of Defensive Medicine," *Duke Law J.*, 939-993, 1971.
3. Bell, R. S., and Loop, J. W.: "The Utility and Futility of Radiologic Skull Examination for Trauma," *New Engl. J. Med.* 284:236-239, 1971.
4. Bergen, R. P.: "Defensive Medicine is Good Medicine," *JAMA* 228:1188-1189, 1974.
5. Havighurst, C. C., and Bovbjerg, R.: "Professional Standards Review Organizations and Health Maintenance Organizations: Are They Compatible?" *Utah Law Rev.* 381-421, 1975.


### Acknowledgement


This work was supported in part by Grant HS01546 to the American College of Radiology from the Health Services Administration, U.S. Public Health Service.



**LOW-COST GROUP INSURANCE ANOTHER ISMS MEMBERSHIP PRIVILEGE**

**THE GROUP DISABILITY PLAN** ● Provides up to $1,732.00 monthly in the event of disability caused by Accident or Sickness. ● Special Guaranteed renewal feature. ● Protect your income and security.

**BUSINESS OVERHEAD EXPENSE PLAN** ● Pays your office overhead expense when disability strikes. ● Premiums are Tax Deductible. ● Pays in Addition to the Disability Plan Benefits.

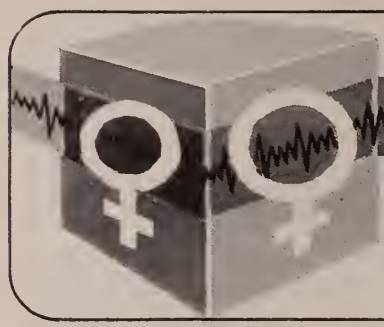
**THE BASIC MAJOR MEDICAL EXPENSE PLAN** ● In or out of Hospital Benefits up to $25,000.00 per Disability. ● Up to $100.00 Daily Hospital Room and Board maximum. ● Subject to choice of deductible and 80% coinsurance.

**EXCESS MAJOR MEDICAL PLAN** ● Provides up to $250,000 for Medical Expenses. ● Supplements **any** Basic Major Medical Plan and has a $25,000 deductible. ● Low group rates. ● Truly **catastrophic coverage.**

FOR INFORMATION, ASSISTANCE & DETAILS CONTACT:

Administrators:
PARKER, ALESHIRE & COMPANY
ESTABLISHED 1901
Insurance

9933 N. Lawler Avenue
Skokie, Illinois 60076
Phone: 312-679-1000



# *pulse...* of the ISMS auxiliary

Mrs. Eugene Vickery, Editor



***KEY LINES:***

By Betty Szewczyk, President, ISMSA

## *New Year Resolution*

*"In the past we have had a light which flickered, in the present we have a light which flames, and in the future there will be a light which shines over all the land and sea."*

*(Churchill)*

We have the privilege of launching a new year and a new fifty years for ISMSA. Our membership, particularly members-at-large, will continue to be nurtured and appreciated, yet we have charted our course to open the door for junior memberships. We realize the need for their young viewpoint and our association would certainly be mutually beneficial.

A top priority among goals for the ISMSA 50th Anniversary Year is to encourage young physicians' spouses to join our membership. Bylaws changes will be necessary and Mrs. Robert Hartman (Bea), our state chairman, and her committee have been diligently preparing for such changes. These will be considered at the annual House of Delegates session in April.

Illinois shares the National Auxiliary's interest in these young and enthusiastic prospective members. Our theme—Appreciate the Past, Anticipate the Future—certainly illustrates our sentiments. Not only must we realize the need for the "numbers" involved, but the exigency of the outlook, the fresh response and the eager desire for involvement.

William J. Mangold, Jr., M.D., Vice Chairman and Resident Physician Member of the AMA Council on Legislation spoke for the AMAA Workshops last fall. He discussed "How To Attract Young Physicians' Spouses" and noted that the auxiliary must create something for the activist—such as legislative campaigns—with which young spouses can identify. Dr. Mangold suggested that apathy was stifling our potential for growth. We must offer jobs and responsibility, not just social time passers. Aim at younger members who demand individual identity—communicate with these new and prospective members as individuals, not just as a "doctor's wife." Dr. Mangold also felt it important to give younger members positions of responsibility and to allow them meaningful input.

Although the AMAA's by-laws already cover membership for "junior/affiliate" members, the board recently approved the appointment of a Task Force to study the structure for a young physician spouse section. The task force will try to determine the needs of young physicians' spouses with the hope of interesting them in membership in the AMA Auxiliary. Eight young physicians' spouses from around the country will

be asked to attend the meeting and offer their views.

This year, one of our Directors, Mrs. Donovan Stiegel (Betty), has been urging county auxiliaries with medical schools and facilities in their area to concentrate on prospective "junior" members and try to find ways to involve them. The presidents of Chicago, Rockford, Peoria, Champaign, Sangamon and Jackson counties, with Betty Stiegel as chairman, have been asked to form a task force to study young physician spouse involvement in Illinois. To cover the situation on all fronts, the newly formed "Long Range Planning" Committee, with President-elect Jane Klaren at its head, has also been asked to work for possible solutions.

The by-laws change under "Membership" which is being considered by the committee at this time reads as follows:

**JUNIOR MEMBERSHIP**—(a) Junior membership shall be granted to spouses of medical students, interns, residents or fellows who are qualified for membership in, but may or may not belong to ISMS, provided that regular membership through a component auxiliary is not available to them. (b) Junior members shall pay dues at a rate set annually by the Board of Directors upon recommendation of the Finance Committee, shall receive official publications, shall have representation in the House of Delegates, but shall be ineligible to hold office.

The Finance Committee has recommended a dues rate of two dollars for ISMSA membership. AMAA "junior/affiliate" membership is currently three dollars—so a junior member would be expected to pay five dollars yearly, plus whatever amount the local auxiliary should designate.

## *Madam . . .*

## *Your PSRO is Showing ! ! !*

You'll learn about PSRO, HMO, NHI and many other issues pertinent to action in 1978 if your plan to attend the Auxiliary Legislative Conference.

On Tuesday, February 7, 1978, you will have the opportunity to learn from talks by AMPAC Representative Tom Norton, ISMS legislative staff and Illinois legislators. Workshops are also planned on campaign strategy.

Registration for the program begins at 9:30 at Baur's Restaurant, 620 S. First Street in Springfield. The registration fee will be $8.00.

Reserve a seat through your county legislative chairman. Don't miss this very informative program.

# Clinics for Crippled Children Listed for February

Thirty-four clinics for Illinois' physically handicapped children have been scheduled for February by the University of Illinois, Division of Services for Crippled Children. The Division will count twenty-three general clinics providing diagnostic orthopedic, pediatric, speech and hearing examination, along with medical social and nursing services. There will be nine special clinics for children with cardiac conditions and two for children with cerebral palsy. Any private physician may refer to or bring to a convenient clinic any child or children for whom he may want examination or consultative services.

February 2 Flora, Clay County Hospital
February 2 Sterling, Community General Hospital
February 2 Lake County Cardiac, Victory Memorial Hospital
February 3 Division Cardiac, U. of I. at the Medical Center
February 7 Park Ridge Cardiac, Lutheran General Hospital
February 8 Jacksonville, Passavant Hospital
February 8 Champaign-Urbana, McKinley Hospital
February 8 Joliet, St. Joseph's Hospital
February 8 Hinsdale, Hinsdale Sanitarium
February 8 Elgin MM, Sherman Hospital
February 9 DuQuoin, Marshall Browning Hospital
February 9 Springfield, St. John's Hospital
February 9 Kankakee, St. Mary's Hospital
February 10 Chicago Heights Cardiac, St. James Hospital
February 13 Peoria Cardiac, St. Francis Hospital
February 14 Anna, Union County Hospital
February 14 Peoria, St. Francis Hospital
February 14 Belleville, St. Elizabeth's Hospital
February 15 Springfield Pediatric Neurology, St. John's Hospital
February 15 Rock Island Cerebral Palsy, Foundation for Crippled Children and Adults
February 15 Chicago Heights, St. James Hospital
February 16 Rockford, Swedish-American Hospital
February 16 Bloomington, Mennonite Hospital
February 16 Elmhurst Cardiac, Memorial Hospital of DuPage County
February 17 Kankakee Cardiac, St. Mary's Hospital
February 21 Rock Island, Moline Public Hospital
February 21 Danville, Lake View Hospital
February 21 E. S. Louis, Christian Welfare Hospital
February 22 Aurora, St. Joseph Mercy Hospital
February 24 Evanston, St. Francis Hospital
February 24 Chicago Heights Cardiac, St. James Hospital
February 27 Peoria Cardiac, St. Francis Hospital
February 27 Maywood, Loyola Medical Center
February 28 Peoria, St. Francis Hospital

The Division of Services for Crippled Children is the official state agency established to provide medical, surgical, corrective and other services and facilities for diagnosis, hospitalization and after-care for children with crippling conditions or who are suffering from conditions that may lead to crippling. In carrying on its program, the Division works cooperatively with local medical societies, hospitals, the Illinois Children's Hospital-School, civic and fraternal clubs, visiting nurse association, local, social and welfare agencies, local chapters of the National Foundation and other interested groups. In all cases the work of the Division is intended to extend and supplement, not supplant, activities of other agencies, either public or private, state or local, carried on in behalf of crippled children.

# ISMS Guide to Continuing Medical Education

Compiled for Illinois physicians by the
ILLINOIS COUNCIL ON CONTINUING MEDICAL EDUCATION
55 E. Monroe St., Suite 3510 • Chicago, IL 60603 • (312) 236-6110

*Items for this Calendar must be received 90 days prior to the event. Those received earlier may appear in up to three monthly issues.*

*WARNING! Items for this Calendar come from many sources, often far in advance of the publication date. Sometimes, cancellations or changes in date, place or time occur too late to be corrected before publication. You are urged to contact the sponsoring organization to confirm information given below.*

## FEBRUARY

### *Emergency Medicine*

**EMERGENCY MEOICINE**
**For:** Emergency Physicians. 5-day workshop course, February 20-24, 1978; 8:00 AM-5:00 PM. Towsley Center, Ann Arbor, MI. **CME Credit:** 36¼ hrs. AAFP Elective and 36¼ hrs. AMA Category 1. **Fee:** $225.00. **Sponsor:** Office of Continuing Education, Dept. of Postgrad. Med. & Health Prof. Educ. **Contact:** Connie Miller, Secretary. **Telephone:** (313) 763-1423.

### *Family Medicine*

**UPOATE ON BREAST CANCER**
**For:** Physicians. Lecture, February 21, 1978; 7:30 PM. Assembly Hall, Sherman Hospital, 934 Center Street, Elgin, IL. **Speaker:** Steven G. Economous, M.D., Prof. of Surgery, Rush Medical College. **CME Credit:** 2 hrs. AMA Category 1. **Fee:** None. **Sponsor:** CME Committee of Sherman Hospital, 934 Center St., Elgin, IL 60120. **Contact:** Mary Anne Stiegemeier, Sec., CME Committee. **Telephone:** (312) 742-9800, Ext. 649.

### *General Surgery Trauma*

**GENERAL SURGERY TRAUMA**
**For:** All Physicians. Hospital Program on General Surgery Trauma, February 28, 1978; 8-10:00 PM. Illinois Masonic Medical Center, 836 W. Wellington, Chicago, IL. **CME Credit:** 2 hrs. AAFP Elective and 2 hrs. AMA Category 1. **Fee:** None. **Sponsor:** Chicago Committee on Trauma of the American College of Surgeons, 11255 W. 74th St., LaGrange, IL 60525. **Contact:** Lillian Husa, Executive Secretary. **Telephone:** (312) 482-8686.

### *Musculo-skeletal Trauma*

**MUSCULO-SKELETAL TRAUMA**
**For:** All Physicians. Hospital Program on Musculoskeletal Trauma, February 14, 1978; 8-10:00 PM. University of Illinois Hospital, 840 S. Wood St., Chicago, IL. **CME Credit:** 2 hrs. AAFP Elective and 2 hrs. AMA Category 1. **Fee:** None. **Sponsor:** Chicago Committee on Trauma of the American College of Surgeons, 11255 W. 74th St., LaGrange, IL. **Contact:** Mrs. Lillian Husa, Executive Secretary. **Telephone:** (312) 482-8686.

### *Pediatrics*

**AUTOSOMAL CHROMOSOMAL ABNORMALITIES**
**For:** All Physicians. Lecture, February 2, 1978; 9:00 AM. Auditorium, St. Joseph Hospital, 2900 N. Lake Shore Dr., Chicago, IL. **Speaker:** George F. Smith, M.D. **CME Credit:** 1 hr. AMA Category 1. **Fee:** None. **Sponsor:** St. Joseph Hospital, Department of Pediatrics, Medical Education, 2900 N. Lake Shore Dr., Chicago, IL. **Contact:** Tina Dabrowski, Secretary. **Telephone:** (312) 975-3454. **Co-Sponsor:** Ross Laboratories.

### *Pediatrics*

**BIOCHEMICAL GENETICS**
**For:** All Physicians. Lecture, February 14, 1978; 9:00 AM. Auditorium, St. Joseph Hospital. **Speaker:** George F. Smith, M.D. **CME Credit:** 1 hr. AMA Category 1. **Fee:** None. **Sponsor:** St. Joseph Hospital, Department of Pediatrics, Medical Education, 2900 N. Lake Shore Dr., Chicago, IL. **Contact:** Tina Dabrowski, Secretary. **Telephone:** (312) 975-3454. **Co-Sponsor:** Ross Laboratories.

### *Pediatrics*

**CHROMOSOMES ANO CANCER**
**For:** All Physicians. Lecture, February 9, 1978; 9:00 AM. Auditroum, St. Joseph Hospital, 2900 N. Lake Shore Dr., Chicago, IL. **Speaker:** George Smith, M.D. **CME Credit:** 1 hr. AMA Category 1. **Fee:** None. **Sponsor:** St. Joseph Hospital, Department of Pediatrics, Medical Education. **Contact:** Tina Dabrowski, Secretary. **Telephone:** (312) 975-3454. **Co-Sponsor:** Ross Laboratories.

### *Pediatrics*

**GENETIC COUNSELING**
**For:** All Physicians. Lecture, February 21, 1978; 9:00 AM. Auditorium, St. Joseph Hospital, 2900 N. Lake Shore Dr., Chicago, IL. **Speaker:** George F. Smith, M.D. **CME Credit:** 1 hr. AMA Category 1. **Fee:** None. **Sponsor:** St. Joseph Hospital, Department of Pediatrics, Medical Education. **Contact:** Tina Dabrowski, Secretary. **Telephone:** (312) 975-3454. **Co-Sponsor:** Ross Laboratories.

### *Pediatrics*

**IMMUNOGENETIC AND PHARMACOGENTIC PROBLEMS**
**For:** All Physicians, Lecture, February 16, 1978, 9:00 AM. Auditorium, St. Joseph Hospital, 2900 N. Lake Shore Dr., Chicago, IL. **Speaker:** George F. Smith, M.D. **CME Credit:** 1 hr. AMA Category 1. **Fee:** None. **Sponsor:** St. Joseph Hospital, Department of Pediatrics, Medical Education. **Contact:** Tina Dabrowski, Secretary. **Telephone:** (312) 975-3454.

### *Pediatrics*

**SEX CHROMOSOMAL ABNORMALITIES**
**For:** All Physicians. Lecture, February 7, 1978; 9:00 AM. Auditorium, St. Joseph Hospital, 2900 N. Lake Shore Dr., Chicago, IL. **Speaker:** George F. Smith, M.D. **CME Credit:** 1 hr. AMA Category 1. **Fee:** None. **Sponsor:** St. Joseph Hospital, Department of Pediatrics, Medical Education. **Contact:** Tina Dabrowski, Secretary. **Telephone:** (312) 975-3454.

### *Psychiatry*

**COPING IN A TROUBLEO SOCIETY**
**For:** Professional Psychiatrists and Psychologists. Symposium, February 16-17, 1978 9:00 AM-6:00 PM, Chicago (Rosemont Area). **Hrs. of Instr.:** 11. **CME Credit:** AMA Category 2. **Fee:** $43.00-$70.00. **Sponsor:** Centaur Enterprises, April Asta, 111 Ontario, Oak Park, IL 60302. **Contact:** Walter Fisher, Subregion Director, 1200 S. First Ave., Madden Mental Health Center, Hines, IL. **Telephone:** (312) 345-9870, ext. 309.

### *Psychiatry*

**PSYCHOTHERAPY OF THE BORDERLINE ADULT: A DEVELOPMENTAL APPROACH**
**For:** Professionals & students in the health field. Lecture, February 1, 1978; 3:00-5:00 PM. Forest Hospital Professional Center, 555 Wilson Lane, Des Plaines, IL. **Speaker:** James Masterson, M.D., Director Group, New York, NY. **CME Credit:** 2 hrs. AMA Category 1. **Fee:** $7-15.00. **Reg. Limit:** 100. **Reg. Deadline:** Advanced registration required. **Sponsor:** Forest Hospital Foundation. **Contact:** Leo Jacobs, M.D., Director of Medical Education. **Telephone:** (312) 872-8811.

### *Psychiatry*

**TOPICS IN AOULT PSYCHIATRY**
**For:** Psychiatrists. 2-day workshop course, February 10-11, 1978; 8:00-5:00 PM. Towsley Center, Ann Arbor, MI. **CME Credit:** 11¼ hrs. AAFP Prescribed, 11¼ hrs. AMA Category 1 and 11¼ hrs. AOA Elective. **Fee:** None. **Sponsor:** Office of Continuing Education, Dept. of Postgrad. Med. & Health Prof. Educ. **Contact:** Connie Miller, Secretary. **Telephone:** (313) 763-1423.

### *Pulmonary Diseases*

**CURRENT TOPICS IN PULMONARY DISEASES**
**For:** Practicing Physicians, Internists, G.P.'s and F.P.'s. Symposium, February 16-17, 1978. Wohl Auditorium, Barnes Hospital Complex, St. Louis, Missouri. **CME Credit:** 12 hrs. AAFP and 12 hrs. AMA Category 1. **Fee:** None. **Reg. Limit:** 150. **Sponsor:** Washington U. School of Medicine, Office of Continuing Medical Education, Box 8063, 660 S. Euclid, St. Louis, MO 63110. **Contact:** Loretta Giacoletto, Administrator Coordinator. **Telephone:** (314) 367-9673.

### *Radiology*

**NEWER DIAGNOSTIC IMAGING TECHNIQUES**
**For:** Physicians. Lecture, February 2, 1978; 2-5:00 PM. 950 E. 59th St., Chicago, IL. **CME Credit:** 3 hrs. AAFP Elective and 3 hrs. AMA Category 1. **Fee:** $20.00. **Sponsor:** University of Chicago, Frontiers of Medicine, 950 E 59th St., Chicago, IL 60637, Box 451. **Contact:** Elaine Ehrman, Secretary. **Telephone:** (312) 947-5777.

### *Sexuality*

**SEXUALLY TRANSMITTEO DISEASES**
**For:** Interested Physicians. 1-day workshop course, February 14, 1978, 8:00-5:00 PM. Towsley Center, Ann Arbor, MI. **CME Credit:** 7 hrs. AAFP Elective, 7 hrs. AMA Category 1 and 7 hrs. AOA. **Fee:** None. **Sponsor:** Office of Continuing Education, Dept. of Postgrad. Med. & Health Prof. Educ., Towsley Center, U-M, Ann Arbor, MI 48109. **Contact:** Connie Miller, Secretary. **Telephone:** (313) 763-1423.

### *Surgery*

**DIAGNOSIS OF MELONOMA**
**For:** Surgeons. Lecture, February 11, 1978, St. Francis Hospital, Evanston, IL. **Speaker:** Edward Scanlan, M.D., Evanston Hospital. **Hrs. of Instr.:** 1. **CME Credit:** AMA Category 1. **Fee:** None. **Sponsor:** St. Francis Hospital, Dept. of Surgery, 355 Ridge, Evanston, IL 60202. **Contact:** Mitchel P. Byrne, M.D., Director of Medical Education. **Telephone:** (312) 492-6227.

## MARCH

### *Colon*

**RECENT ADVANCES IN COLORECTAL CANCER**
**For:** Physicians. Lectures, March 8, 1978, 9:00 AM, 950 E. 59th St., Chicago, IL. **Hrs. of Instr.:** 6. **CME Credit:** AAFP Elective and AMA Category 1. **Fee:** $30.00. **Sponsor:** University of Chicago, Frontiers of Medicine, 950 E. 59th St., Chicago, IL. **Contact:** Elaine Ehrman, Secretary. **Telephone:** (312) 947-5777.

### *Family Medicine*

**EXPECTED USE OF BLOOD IN ELECTIVE SURGERY**
**For:** Physicians. Lecture, March 14, 1978, 7:30 PM, Assembly Hall, Sherman Hospital, 934 Center Street, Elgin, IL. **Speaker:** John B. Henry, M.D., Dir. of Clinical Lab., Upstate Medical Center. **Hrs. of Instr.:** 2. **CME Credit:** AMA Category 1. **Fee:** None. **Sponsor:** Continuing Medical Education Committee, Sherman Hospital, 934 Center St., Elgin, IL. **Contact:** Mary Anne Stiegemeier, Secretary, CME Committee. **Telephone:** (312) 742-9800, Ext. 649.

### *Family Medicine*

**NEUROLOGICAL PROBLEMS IN FAMILY PRACTICE**
**For:** Family physicians. Two-day workshop course, March 30-31, 1978, 8:00 AM, Towsley Center, Ann Arbor, MI. **Hrs. of Instr.:** 14. **CME Credit:** AAFP Elective, AMA Category 1 and AOA. **Fee:** None. **Sponsor:** Office of Continuing Education, Dept. of Postgrad. Med. & Health Prof. Educ., Towsley Center, U-M, Ann Arbor, MI. **Contact:** Connie Miller, Secretary. **Telephone:** (313) 763-1423.

### *General Medicine*

**CARE OF THE BURNEO PATIENT**
**For:** Nurses, and other health professionals. One-day workshop course, March 3, 1978, Towsley Center, Ann Arbor, MI. **Hrs. of Instr.:** 6½. **CME Credit:** AAFP Elective and AMA Category 1. **Fee:** $15.00. **Sponsor:** Office of Continuing Education, Towsley Center, U-M, Ann Arbor, MI. **Contact:** Connie Miller, Secretary. **Telephone:** (313) 763-1423.

*Hematology*

**HEMATOLOGY REVIEW**
**For:** Pathologists and M.T. Three-day workshop course, March 8-10, 1978, Towsley Center, Ann Arbor, MI. **Hrs. of Instr.:** 21. **CME Credit:** AAFP Elective, AOA and AMA Category 1. **Fee:** None. **Sponsor:** Office of Continuing Education, Towsley Center, U-M, Ann Arbor, MI. **Contact:** Connie Miller, Secretary. **Telephone:** (313) 763-1423.

*Infectious Diseases*

**CURRENT TOPICS IN INFECTIOUS DISEASES**
**For:** Practicing physicians. Symposium, March 16-17, 1978, Wohl Auditorium, Barnes Hospital Complex, St. Louis, MO. **Hrs. of Instr.:** 12. **CME Credit:** AAFP and Category 1. **Fee:** $120.00. **Sponsor:** Washington U. School of Medicine, Office of Continuing Medical Education, Box 8063, 660 Euclid, St. Louis, MO. **Contact:** Loretta Giacoletto, Administrative Coordinator. **Telephone:** (314) 367-9673.

*Medicine/Surgery*

**NINETEENTH MEDICAL/SURGICAL SEMINAR FOR LAKE COUNTY**
**For:** Physicians. Seminar, March 22, 1978, Mother Leonarda Hall, St. Theresa Hospital, Waukegan, IL. **Hrs. of Instr.:** 5. **CME Credit:** AAFP Elective, AMA Category 1 and AOA. **Fee:** None. **Reg. Deadline:** March 20, 1978. **Sponsor:** St. Therese Hospital, 2615 Washington St., Waukegan, IL. **Contact:** R. M. Adelman, D.D.S., M.D. **Telephone:** (312) 688-5800.

*Musculo-Skeletal & General Surgery Trauma*

**MUSCULO-SKELETAL & GENERAL SURGERY TRAUMA**
**For:** All physicians. Hospital program, March 21, 1978, 8:00 PM, South Suburban Hospital, 178th Kedzie Ave., Hazel Crest, IL. **Hrs. of Instr.:** 2. **CME Credit:** AAFP Elective and AMA Category 1. **Fee:** None. **Sponsor:** Chicago Committee on Trauma of the American College of Surgeons, 11255 W. 74th St., LaGrange, IL. **Contact:** Mrs. Lillian Husa, Executive Secretary. **Telephone:** (312) 482-8686.

*Pediatrics*

**ADVANCES IN PEDIATRICS**
**For:** Pediatricians. Two-day workshop course, March 22-23, 1978, 8:00 AM, Towsley Center, Ann Arbor, MI. **Hrs. of Instr.:** 14. **CME Credit:** AAFP Elective, AMA Category 1 and AOA Elective. **Fee:** $120.00. **Sponsor:** Office of Continuing Education, Towsley Center, U-M, Ann Arbor, MI. **Contact:** Connie Miller, Secretary. **Telephone:** (313) 763-1423.

*Psychiatry*

**ALEXITHYMIA: A RECONSIDERATION OF THE PSYCHOSOMATIC PROCESS**
**For:** Professionals & students in the health field. Lecture, March 1, 1978, 3:00 PM, Forest Hospital Professional Center, 555 Wilson Lane, Des Plaines, IL. **Speaker:** John C. Nemiah, M.D., Psychiatrist-in-Chief, Beth Israel Hosp., Boston Mass. **Hrs. of Instr.:** 2. **CME Credit:** AMA Category 1. **Fee:** $7.00 Students and $15.00 Prof. **Reg. Deadline:** Advanced registration. **Reg. Limit:** 100. **Sponsor:** Forest Hospital, 555 Wilson Lane, Des Plaines, IL. **Contact:** Leo Jacobs, M.D., Director of Medical Education. **Telephone:** (312) 827-8811.

*Psychiatry*

**FUTURE DIRECTIONS IN DMH AND DEVELOPMENTAL DISABILITIES**
**For:** Psychiatrist and Mental Health Profession. Lecture series, March 15, 1978, 8:00 PM, Offield Auditorium, Passavant Pavilion, 303 E. Superior St., Chicago, IL. **Speaker:** Robert A. deVito, M.D., Director, Illinois Department of Mental Health. **Hrs. of Instr.:** 1½. **CME Credit:** AMA Category 1. **Fee:** None. **Sponsor:** Institute of Psychiatry, Northwestern University Medical School, 320 E. Huron St., Chicago, IL. **Contact:** Leon Diamond, M.D., Director of Graduate Education. **Telephone:** (312) 649-8058.

*Rheumatology*

**RHEUMATOLOGY FOR THE PRACTICING PHYSICIAN**
**For:** Internists, Family and General Practice. Symposium, March 2-3, 1978, Wohl Auditorium, Barnes Hospital Complex, St. Louis, MO. **Hrs. of Instr.:** 9. **CME Credit:** AAFP and AMA Category 1. **Fee:** $90.00. **Reg. Limit:** 150. **Sponsor:** Washington University School of Medicine, Office of Continuing Medical Education, Box 8063, 660 South Euclid, St. Louis, MO. **Contact:** Loretta Giacoletto, Administrative Coordinator. **Telephone:** (314) 367-9673.

*Surgery*

**MARKED OBESITY**
**For:** Surgeons. Lecture, March 11, 1978 at 7:30 AM, St. Francis Hospital, Evanston, IL. **Speaker:** Donald Ferguson, M.D., University of Chicago, Chicago, IL. **Hrs. of Instr.:** 1. **CME Credit:** AMA Category 1. **Fee:** None. **Sponsor:** St. Francis Hospital, Dept. of Surgery, 355 Ridge, Evanston, IL 60202. **Contact:** Mitchel P. Byrne, M.D., Dir. Medical Education. **Telephone:** (312) 492-6227.

*Surgery*

**NEWER CONCEPTS IN GASTROINTESTINAL SURGERY**
**For:** General surgeons. Two-day workshop course, March 16-17, 1978, Towsley Center, Ann Arbor, MI. **Hrs. of Instr.:** 14. **CME Credit:** AAFP Elective, AMA Category 1 and AOA Elective. **Fee:** $130.00. **Sponsor:** Office of Continuing Education, Towsley Center, U-M, Ann Arbor, MI. **Contact:** Connie Miller, Secretary. **Telephone:** (313) 763-1423.

*Surgery*

**SURGICAL GRAND ROUNDS**
**For:** House Staff. Lecture, March 4, 1978 at 7:30 AM, Evanston, IL. **Speaker:** Robert Wilson, M.D. Wayne State-Detroit, MI. **Hrs. of Instr.:** 1. **CME Credit:** AMA Category 1. **Fee:** None. **Sponsor:** St. Francis Hospital, 355 Ridge, Evanston, IL 60202. **Contact:** Mitchel Byrne, M.D., Director of Medical Education. **Telephone:** (312) 492-6229.

*Urology*

**SECOND ANNUAL UROLOGY CONFERENCE**
**For:** Urologists. Conference, March 3-4, 1978, Chicago, IL. **Hrs. of Instr.:** 18. **CME Credit:** AMA Category 1. **Fee:** $150.00. **Reg. Limit:** 250. **Sponsor:** Northwestern University Medical School, Center for Continuing Education, 301 E. Chicago Ave., Chicago, IL. **Contact:** James Dyson, Ph.D., Director of Continuing Education. **Telephone** (312) 649-8533.

# *APRIL*

*Cancer*

**PASTORAL CARE & CANCER**
**For:** Clergy. 1-day workshop course, April 26, 1978; 8:00 AM to 5:00 PM, Towsley Center, Ann Arbor, MI. **Hrs. of Instr.:** 6. **CME Credit:** AMA Category 1, AAFP Elective and AOA Elective. **Fee:** $20.00. **Sponsor:** Office of Continuing Education, Dept. of Postgrad. Medicine & Health Prof. Education, Towsley Center, U-M, Ann Arbor, MI. **Co-Sponsor:** American Cancer Society. **Contact:** Connie Miller, Secretary. **Telephone:** (313) 763-1423.

*Family Medicine*

**DETECTION AND MANAGEMENT OF CERVICAL CANCER**
**For:** Physicians. Lecture, April 18, 1978, Assembly Hall, Sherman Hospital, 934 Center Street, Elgin, IL. **Speaker:** Robert C. Stepto, M.D., Ph.D. Prof. of Ob-Gyn. Rush Medical College, Chm. Ob-Gyn. Dept., Mount Sinai Hospital. **Hrs. of Instr.:** 2. **CME Credit:** AMA Category 1. **Fee:** None. **Sponsor:** Continuing Medical Education Committee of Sherman Hospital, 934 Center Street, Elgin, IL. 60120. **Contact:** Mary Anne Stiegemeier, Sec., CME Committee. **Telephone:** (312) 742-9800, ext. 649.

*Family Medicine*

**EKG DIAGNOSIS**
**For:** Family Physicians and Int. Med. 3-day workshop course, April 11-13, 1978, 8:00 AM to 5:00 PM, at Towsley Center, Ann Arbor, MI. **Hrs. of Instr.:** 23½. **CME Credit:** AAFP Elective, AMA Category 1 and AOA Elective. **Fee:** None. **Sponsor:** Office of Continuing Education, Dept. of Postgrad. Med. & Health Prof. Education, Towsley Center, U-M, Ann Arbor, MI. **Contact:** Connie Miller, Secretary. **Telephone:** (313) 763-1423.

*Family Medicine*

**FAMILY PRACTICE REVIEW II**
**For:** Family Physicians. 5-day workshop course, April 17-21, 1978; 8:00 AM to 5:00 PM, Towsley Center, Ann Arbor, MI. **Hrs. of Instr.:** 37. **CME Credit:** AAFP Elective, AMA Category 1 and AOA Elective. **Fee:** $250.00. **Sponsor:** Office of Continuing Education, Dept. of Postgrad. Med. & Health Prof. Education, Towsley Center, U-M, Ann Arbor, MI. **Contact:** Connie Miller, Secretary. **Telephone:** (313) 763-1423.

*Musculo-skeletal Trauma*

**CLINICAL HOSPITAL PROGRAM ON MUSCULO-SKELETAL TRAUMA**
**For:** All Physicians. Hospital program, April 18, 1978 8:00 PM to 10:00 PM, Little Company of Mary Hospital, 2800 W. 95th St., Evergreen Park, IL. **Hrs. of Instr.:** 2. **CME Credit:** AAFP Elective and AMA Category 1. **Fee:** None. **Sponsor:** Chicago Committee on Trauma of the American College of Surgeons. **Contact:** Mrs. Lillian Husa, Executive Secretary. **Telephone:** (312) 482-8686.

*Obstetrics/Gynecology*

**OB/GYN CONFERENCE**
**For:** Ob/Gyn. 2-day workshop course, April 4-5, 1978, 8:00 AM to 5:00 PM, Towsley Center, Ann Arbor, MI. **Hrs. of Instr.:** 11½. **CME Credit:** AAFP Elective, AMA Category 1 and AOA Elective. **Fee:** $100.00. **Sponsor:** Office of Continuing Education, Dept. of Postgrad. Med. & Health Prof. Education, Towsley Center, Ann Arbor, MI. **Co-Sponsor:** MSOG. **Contact:** Connie Miller, Secretary. **Telephone:** (313) 763-1423.

*Ophthalmology*

**OPHTHALMOLOGY CONFERENCE**
**For:** Ophthalmologists. 2-day workshop course, April 6-7, 1978, 8:00 AM to 5:00 PM, Towsley Center, Ann Arbor, MI. **Hrs. of Instr.:** 14. **CME Credit:** AAFP Elective, AMA Category 1 and AOA Elective. **Fee:** $140.00. **Sponsor:** Office of Continuing Education, Dept. of Postgrad. Med. & Health Prof. Education, Towsley Center, U-M, Ann Arbor, MI. **Contact:** Connie Miller, Secretary. **Telephone:** (313) 763-1423.

*Psychiatry*

**DISTINGUISHED GUEST LECTURE SERIES**
**For:** Psychiatrists and Mental Health Professionals. Lecture series, April 19, 1978, 8:00 PM, Offield Auditorium, Passavant Pavilion, 303 East Superior, Chicago, IL. **Speaker:** Allan Biegel, M.D., Associate Professor, University of Arizona College of Medicine. **Hrs. of Instr.:** 1½. **CME Credit:** AMA Category 1. **Fee:** None. **Sponsor:** Institute of Psychiatry, Northwestern University Medical School, 320 E. Huron Street, Chicago, IL. **Contact:** Leon Diamond, M.D., Director of Graduate Education. **Telephone:** (312) 649-8058.

*Psychiatry*

**HYSTERIA IN CHILDREN**
**For:** Psychiatrists, social workers and therapists. Symposium, April 17-18, 1978, Erlanger Auditorium. McDonnel Science Building, 4570 McKinley, St. Louis, MO. **Hrs. of Instr.:** 9. **CME Credit:** AMA Category 1. **Fee:** None. **Reg. Limit:** 150. **Sponsor:** Continuing Medical Education, Washington University School of Medicine, 660 South Euclid, Box 8063, St. Louis, MO. 63110. **Co-Sponsor:** Child Guidance Clinic, 369 North Taylor, St. Louis, Missouri. **Contact:** Loretta Giacoletto, Administrative Coordinator. **Telephone:** (314) 367-9673.

*Psychiatry*

**PSYCHOTHERAPY OF PSYCHOTIC DEPRESSION**
**For:** Professionals & students in the health field. Lecture, April 5, 1978 at 3:00 PM to 5:00 PM, Forest Hospital Professional Center, 555 Wilson Lane, Des Plaines, IL. **Speaker:** Silvano Arieti, M.D., Clinical Prof. of Psychiatry. New York Medical College. **Hrs. of Instr.:** 2. **CME Credit:** AMA Category 1. **Fee:** $7.00-$15.00. **Reg. Limit:** 100. **Reg. Deadline:** Advanced registration required. **Sponsor:** Forest Hospital Foundation, 555 Wilson Lane, Des Plaines, IL. **Contact:** Leo Jacobs, M.D., Director of Medical Education. **Telephone:** (312) 827-8811.

*Surgery*

**SURGICAL GRAND ROUNDS**
**For:** House Staff. Lecture, April 15, 1978, Evanston, IL. **Speaker:** Jack Pickelman, M.D. **Hrs. of Instr.:** 1. **CME Credit:** AMA Category 1. **Fee:** None. **Sponsor:** St. Francis Hospital, 355 Ridge, Evanston, IL 60202. **Contact:** Mitchel P. Byrne, M.D., Director of Medical Education. **Telephone:** (312) 492-6229.

*Surgery-Vascular*

**CEREBROVASCULAR DISEASE AND RENOVASCULAR HYPERTENSION**
**For:** Physicians. Lecture, April 12, 1978 at 9:00 AM-5:00 PM, 950 East 59th Street, Chicago, IL. **Hrs. of Instr.:** 6. **CME Credit:** AAFP Elective and AMA Category 1. **Fee:** $30.00. **Sponsor:** University of Chicago, 950 East 59th St., Chicago, IL. **Contact:** Elaine Ehrman, Secretary. **Telephone:** 947-5777.

*Venous & Arterial Thrombosis*

**VENOUS & ARTERIAL THROMBOSIS: CURRENT STATUS OF DIAGNOSIS, PREVENTION & THERAPY**
**For:** Internists, Family & General Practitioners. Symposium, April 6-7, 1978, Wohl Auditorium, Barnes Hospital Complex, St. Louis, MO. **Hrs. of Instr.:** 12, **CME Credit:** AAFP and AMA Category 1. **Fee:** $120.00. **Reg. Limit:** 150. **Sponsor:** Washington University School of Medicine, Office of Continuing Medical Education, Box 8063, 660 S. Euclid, St. Louis, MO. **Contact:** Loretta Giacoletto, Administrative Coord. **Telephone:** (314) 367-9673.


**CANCER INFORMATION SERVICE FOR ILLINOIS**
**800-972-0586**

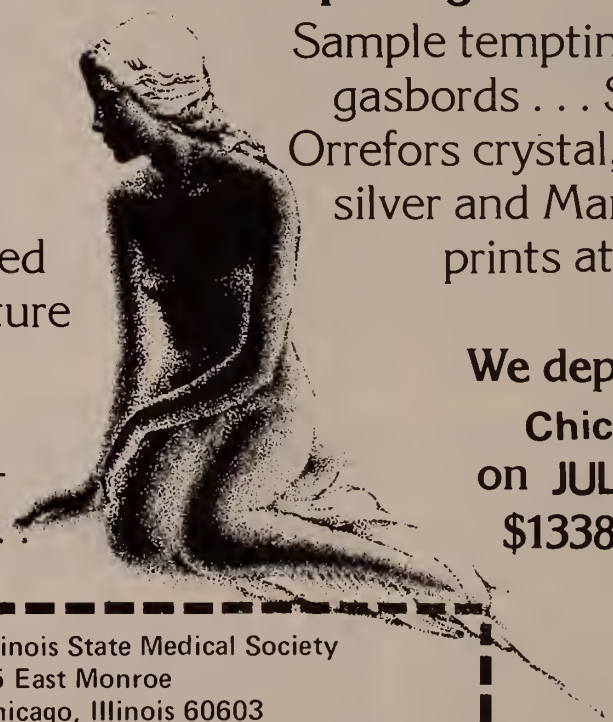
**Illinois physicians may call this toll-free number for quick, easy access to a panel of cancer specialists for specific patient consultation.**

**Sponsored by:**
**Illinois Cancer Council**
**36 South Wabash Avenue**
**Chicago, IL 60603**

# Scandinavian Adventure

**SWEDEN • FINLAND • DENMARK**
**With Optional Excursions to OSLO and LENINGRAD**
**A Two Week Luxury Holiday In the Land of the Vikings**
**Stockholm – Helsinki – Copenhagen**

Sail through glistening blue harbors. See the Midnight Sun . . . Relax in a luxurious sauna . . . Visit the walled city of Visby . . . Recapture your happy childhood in Tivoli Gardens . . . Admire Hamlet's medieval Kronborg Castle . . .



Sample tempting smorgasbords . . . Shop for Orrefors crystal, Jensen silver and Marimekko prints at bargain prices.

**We depart Chicago on JULY 2, 1978**
**$1338**

Send To: Illinois State Medical Society
55 East Monroe
Chicago, Illinois 60603

Enclosed is my check for $ _____ $100 per person as deposit.

Names _____

Address _____

City _____ State _____ Zip _____

Space Strictly Limited—Make Reservations Now

A Non-Regimented INTRAV® Deluxe Adventure

# Summary of Actions 1977 Interim Session of the House of Delegates

## REFERENCE COMMITTEE ON AMENDMENTS TO CONSTITUTION & BYLAWS

Referred to the Board of Trustees proposed amendments to clarify Chapter X of the Bylaws, particularly in regard to reinstatement of members who resign voluntarily.

## REFERENCE COMMITTEE A

1. Directed AMA Delegation to urge that AMA encourage a diversified clinically oriented first year of postgraduate training throughout the country.

2. Rejected a proposal to provide county societies with greater autonomy than they currently enjoy. Existing policy only restricts local autonomy when it conflicts with ISMS bylaws or AMA Principles of Medical Ethics.

3. Supported continued election of AMA presidents by the House of Delegates. Directed AMA delegation to seek bylaw amendment to allow elected president to succeed himself.

4. Directed Speaker of the House to appoint a study committee to recommend revisions in the society's disciplinary and peer review procedures. Referred to the Board of Trustees for study by this ad hoc committee a proposal that substantive matters be considered in peer review appeals.

5. Directed AMA Delegation to seek changes in AMA House of Delegates procedures so that:
   (A) Reference committee reports would reflect opinions of committee members, rather than resource personnel; and
   (B) All members of the House be rotated through reference committees as members and chairmen.

6. Agreed that:
   (A) CME course sponsors should provide full disclosure of materials, methods, objectives and evaluation procedures of offered courses; and
   (B) ISMS Board of Trustees should study the practicality, cost and effectiveness of establishing a uniform and official system for the continuing collection, tabulation, and recording of CME Category 1 credits earned by ISMS members attending CME courses.

7. Rejected a proposal to request AMA action to discourage discrimination against hospital-based physicians because the need for this action was not substantiated.

8. Agreed to request the Illinois State Medical Inter-Insurance Exchange to provide component societies, on request, information regarding
   (A) Number of policy holders by county;
   (B) Number of claims filed in the past three years by county; and
   (C) Disposition of these cases.

9. Agreed to encourage and assist component societies—or groups of component societies—to become accredited bodies for providing continuing medical education.

10. Requested Board of Trustees to study the cost, effectiveness and possible restructuring of the Interim Session of the House of Delegates and report back to the House at the 1978 annual meeting.

11. Again rejected a proposal to dissolve unified membership with AMA, but agreed that some benefits should accrue to members in unified states.

12. (A) Directed Board of Trustees to consider mounting a public education campaign on the importance of good nutrition, emphasizing the need for teaching nutrition in primary and secondary schools;
    (B) Called upon AMA to request American Association of Medical Colleges to make nutrition part of the core curriculum in all medical schools; and
    (C) Encouraged Student Business Session and Resident Physician Section to introduce similar resolutions in the AMA House of Delegates.

## REFERENCE COMMITTEE B

1. Adopted the following plans for negotiating with the Illinois Department of Public Aid:
    (A) ISMS to develop and implement a Physician-IDPA Agreement Form insuring physician and patient rights under the Medicaid program;
    (B) ISMS to negotiate with IDPA to develop an alternative, more equitable payment method;
    (C) Board of Trustees authorized to take legal action, if necessary, to resolve ISMS' concerns regarding the department's administrative procedures; and
    (D) If such litigation becomes necessary, it should be financed by a dues increase or from reserve funds, with the Board of Trustees selecting and implementing the most feasible method.

2. Agreed to request Illinois Department of Public Aid Director to investigate immediately the tactics of departmental auditors and special investigators and take whatever corrective steps necessary to prevent questionable investigative procedures being used against physicians.

3. Directed the Society to request of IDPA an explanation of its proposal allowing Medicaid vendor payments to be sent to only one address. Referred to the Board of Trustees—for negotiation with IDPA—a resolution calling upon ISMS to block the Department's proposal.

4. Agreed that AMA and ISMS should vigorously undertake those activities necessary, including but not limited to legislation, to ensure that the Physicians Current Procedural Terminology, Edition IV—or later editions, is recognized and accepted by all governmental and third party payors and a report furnished to ISMS House of Delegates at each meeting until accomplished.

5. Directed the AMA Delegation to request the AMA, through legislative or judicial means, to obtain recission of the use of 1971 base year data or the use of any other base year data on a permanent basis, for any Medicare calculations, and that the AMA seek abolishment of the use of an economic index applied to Medicare reimbursement calculations.

6. Agreed that ISMS should encourage cost sharing by patients in all medical care reimbursement plans.

7. Directed the Board of Trustees to record and document—when possible—those areas in which quality of medical care is compromised by governmental health programs. Encouraged physicians to employ the "Medicare Misconceptions" booklet and "Drift Toward a National Health Service" program as a warning to citizens that a serious decline in quality of medical care can be expected should broad scale national health insurance and/or national health service be imposed.

## REFERENCE COMMITTEE C

1. Directed AMA Delegation to:
    (A) Introduce a resolution mandating a vigorous public relations campaign to maintain the medical profession's image of respect and integrity; and
    (B) Challenge the distorted public messages—including distorted information about medical costs—issued by groups hostile to medicine.

2. (A) Authorized Illinois Foundation for Medical Care to investigate and, if economically feasible, implement programs for supporting physician organizations endorsed by constituent medical societies. Such support is to be in the area of data needs, statewide coordination, statistical analysis, coordinated negotiations and support of state level organizations and public, governmental or private funds may be utilized to reimburse the foundation for such activities.
   (B) IFMC specifically authorized to investigate feasibility of becoming a statewide support center for physician organizations endorsed by constituent medical societies.

3. Referred to Board of Trustees for consideration a proposal that ISMS, in conjunction with private enterprise, develop and implement a statewide voluntary medical and surgical care program such as an individual practice association for individuals and/or groups and commercial contract agreements for private enterprise.

4. Referred to Board of Trustees a proposal that ISMS urge all hospital governing boards to grant hospital privileges on the basis of experience and peer assessment of performance, and such not be contingent upon results of recertification examinations.

5. Agreed that ISMS should work with the Illinois Hospital Association to assure that each physician receives a copy of the hospital bill of each patient he hospitalizes as a voluntary step toward cost containment of health care.

6. Rejected a plan for protesting Blue Shield's recent declaration that it would no longer routinely pay for certain named surgical and diagnostic procedures.

7. Declared opposition to any intent or attempt by Blue Cross/Blue Shield or other third party payors to institute utilization review of hospital patients in the private sector which bypasses local physician review mechanisms and directed AMA delegation to introduce similar resolution in AMA House of Delegates.

8. Agreed to oppose third-party differentiation between covered services provided by participating and non-participating physicians as discriminatory against the physician who does not have a separate contractual relationship with the carrier and inhibiting the patient's free choice of physicians. This position will be communicated to all Illinois health insurance carriers through the Health Insurance Association and to the AMA House of Delegates.

9. Referred to the Board of Trustees for further study a proposal that ISMS identify those areas having an acute shortage of health care personnel and facilities and to study the respective inequities among these areas.

10. Also referred to the Board was a proposal that ISMS do a feasibility study at a select number of agreeable institutions on a short-term basis to ascertain the documented implications of institutions working on a full seven-day work week as opposed to a five-day work week.

11. Agreed to seek legislative assistance for establishing disaster teams outside the immediate disaster area, confirming the need for such teams and developing appropriate communications for mobilizing them at times of documented need.

12. Supported the concept of increased insurance coverage for out-patient diagnostic tests and agreed to undertake a dialogue with the insurance industry to implement such policies in Illinois.

## REFERENCE COMMITTEE D

1. Agreed to encourage legislation that would provide Congress with oversight of all regulations relating to utilization review and PSRO review in order that confidentiality of all health records be maintained, preventing access to such records by the federal bureaucracy and encouraged the AMA to act similarly.

2. Agreed to:
   (A) Initiate legislation to repeal all provisions of HB 1080, which amended the Illinois Insurance Code to provide for compulsory insurance coverage of non-medical independent practitioners (psychologists); and

(B) Oppose HB 921/SB 553 which provides for compulsory insurance coverage of independent social workers, without reliance on any amendments.

3. Agreed to inform the Illinois Department of Public Health and any other agency, when appropriate, that Section 16 (i) of the Medical Practice Act identifies certain acts which should not be done without a license to practice medicine, to wit: "The diagnosis or treatment of ailments of human beings . . ." and that such notice or information urge strict compliance with the statute.

4. Adopted a policy on violence which:
   (A) Urges stricter enforcement of present federal, state and city laws pertaining to violent crimes and urges the legislature to consider increased penalties and the courts to impose maximum penalties allowed by laws on all offenders;
   (B) Directs the Board of Trustees to study the social problems of violence, establish a formal posture embracing opposition to violence and all its ramifications, and recommend a policy to the House;
   (C) Authorizes the society, in cooperation with law enforcement agencies, to take an active interest in the apprehension and prosecution of those persons committing assaults on physicians, including consideration for offering rewards and other incentives in the solution of such cases; and
   (D) Directs the AMA delegation to introduce a similar resolution in the AMA House of Delegates.

5. Adopted a policy on safeguarding human rights which states that:
   (A) ISMS shall dedicate itself to preserving our incomparable political system and the priceless human rights upon which it is founded; and
   (B) Every member of ISMS should be made aware of the pressing need for both their moral and monetary support of those individuals and organizations that devote themselves to constitutional government and the preservation of human rights. This policy will be forwarded to AMA for adoption by its House of Delegates.

   A proposal that a special task force be created to study and implement the spirit of and intent of this resolution was referred to the Board of Trustees.

6. Requested the Board of Trustees to define what constitutes an adequate premarital medical examination and transmit this information to the legislature for reviewing and modifying the law to eliminate any existing ambiguity and confusion about this issue, encouraging the enforcement of one uniform reporting form throughout the state.

## REFERENCE COMMITTEE E

1. Referred to the Board of Trustees a proposal that ISMS support the concept of a state-provided catastrophic illness and injury insurance plan.

2. Also referred to the Board were proposals to publicize the shortcomings of present government health programs as a means of opposing compulsory federally mandated health insurance.

3. Supported and strongly recommended a system of tax credits for the cost of medical services, drugs and health insurance.

4. Reaffirmed opposition to compulsory, governmentally-mandated National Health Insurance.

5. Rejected a plan to ask AMA to withdraw support from its national health insurance bill.

6. Referred to the Governmental Affairs Council recommendations for amending the AMA's National Health Insurance legislation, HR 1818 and S 18, to eliminate "onerous controls and dangerous precedents" regarding employer contributions, surcharges and federal control boards.

## ELECTIONS

Morris Friedell, M.D., Chicago, was elected to fill the unexpired term of the late Charles Schlageter, M.D., as an alternate delegate to the American Medical Association. The term expires Dec. 31, 1978.

# Actions on Resolutions November, 1977 Interim Session House of Delegates

| *Number* | *Introduced By:* | *Subject* | *Action* |
|---|---|---|---|
| **Reference Committee on Constitution & Bylaws** | | | |
| 77N-1 | James Laidlaw | Amendment to Section 10 of Chapter X | Referred to B of T & Bylaws Committee |
| **Reference Committee "A"** | | | |
| 77N-6 | Morgan M. Meyer | Rotating Internships | Substitute adopted |
| 77N-10 | Guy A. Pandola | Amendment to Article III of the Constitution & Bylaws of ISMS | Rejected |
| 77N-11 | J. M. Ingalls | Election of AMA President | Adopted as amended |
| 77N-16 | Eugene P. Johnson<br>William A. Hutchison<br>C. DeKovessey<br>Fred A. Tworoger<br>Frank C. Sedlak<br>A. Beaumont Johnson | Rescinding Substantive Exclusion from Peer Review Appeals | Referred to B of T for study by special Ad Hoc Committee of the H of D |
| 77N-20 | David S. Fox | Revisions of Disciplinary & Peer Review Procedures | Adopted |
| 77N-33 | Donald Quinlan | The Role of Reference Committees in the AMA's House of Delegates | Adopted as amended & editorially changed |
| 77N-38 | August M. Rossetti | CME Category I Credit Tabulation and Sponsor Responsibility | Substitute adopted |
| 77N-39 | H. Frank Holman | Discrimination Against Hospital-Based Physicians | Rejected |
| 77N-44 | George J. Shimkus | Availability of Information from the ISMIE | Adopted as amended & editorially changed |
| 77N-46 | John Ring | Continuing Medical Education | Adopted as amended & editorially changed |
| 77N-47 | John Ring | Interim Meeting of ISMS H of D | Substitute adopted |
| 77N-48 | Walter P. Plassman | Unified Membership with AMA | Rejected |
| 77N-51 | Robert L. Cavens | Nutrition Courses in Medicine | Adopted as amended |

| *Number* | *Introduced By:* | *Subject* | *Action* |
|---|---|---|---|
| **Reference Committee "B"** | | | |
| 77N-4 | Thomas W. Stach | Encouraging Use of CPT-4 | Substitute adopted as editorially changed |
| 77N-5 | Thomas W. Stach | Rescission of 1971 Base Year Data | Adopted |
| 77N-12 | George Lagorio | Dr. Thomas Kovachevich and IDPA | Substitute adopted |
| 77N-26 | Edward K. DuVivier | Discouraging Total Medical Care Reimbursements by Third Party Payors | Substitute adopted as amended |
| 77N-29 | Franklin Lounsbury | Medicare Outdated Procedural Codes | Rejected |
| 77N-34 | Finley W. Brown, Jr. | Ninety-Two Pound Weakling | Rejected |
| 77N-35 | Finley W. Brown, Jr. | Hopelessness of Situation with IDPA | Rejected |
| 77N-36 | Finley W. Brown, Jr. | Quality of Care | Substitute adopted as amended |
| 77N-37 | Finley W. Brown, Jr. | Punishment by Accounting Rules | Referred to B of T |
| 77N-56 | Robert R. Hartman | ISMS-IDPA Negotiations | Adopted as amended |
| **Reference Committee "C"** | | | |
| 77N-3 | Joseph R. O'Donnell | Public Relations Program Regarding Aetna Earnings | Rejected |
| 77N-7 | Joseph R. O'Donnell | Aetna | Rejected |
| 77N-8 | Thomas W. Stach | Public Relations Program | Adopted |
| 77N-22 | Joseph Sherrick<br>Robert P. Johnson<br>James M. Laidlaw<br>Audley Connor<br>Miller L. Henderson<br>Lawrence L. Hirsch | Illinois Foundation for Medical Care | Adopted as amended |
| 77N-24 | C. B. Lara | Development of Voluntary Medical-Surgical Care Program | Referred to B of T |
| 77N-25 | Robert Hamilton | Withholding Hospital Privileges | Substitute referred to B of T |
| 77N-27 | Robert Hamilton | Cost Containment | Adopted |
| 77N-41 | Thomas P. Meirink | Blue Shield's Action Regarding Payment for Certain Surgical and Diagnostic Procedures | Rejected |
| 77N-42 | Thomas P. Meirink | Utilization Review by Blue Cross/Blue Shield | Substitute adopted |

| *Number* | *Introduced By:* | *Subject* | *Action* |
|---|---|---|---|
| 77N-45 | David S. Helberg | Third-Party Carrier Discrimination against "Non-Participating" Physicians | Adopted |
| 77N-50 | Robert L. Cavens | Shortage of Health Care Personnel and Facilities | Referred to B of T |
| 77N-52 | Robert L. Cavens | Health Care Institutions Functioning 7 Days | Referred to B of T |
| 77N-53 | Robert L. Cavens | Disaster Teams | Adopted |
| 77N-54 | Robert L. Cavens | Insurance Coverage for Out-Patient Diagnostic Tests | Adopted |
| **Reference Committee "D"** | | | |
| 77N-2 | Joseph R. O'Donnell | Confidentiality | Substitute adopted |
| 77N-23 | Thomas W. Stach | Repeal of Insurance Code Amendments | Adopted as editorially changed |
| 77N-28 | Edward K. DuVivier | Authority to Make a "Diagnosis" | Substitute adopted |
| 77N-30 | Franklin Lounsbury | Policy on Violence | Substitute adopted |
| 77N-40 | H. Frank Holman | Safeguarding Human Rights | Adopted RESOLVES 1, 2 & 4—3rd RESOLVE Referred to B of T |
| 77N-55 | Gonzalo Ruiz | Premarital Medical Examinations | Substitute adopted |
| **Reference Committee "E"** | | | |
| 77N-9 | Harry Darland | Catastrophic Illness & Injury Insurance | Referred to B of T |
| 77N-17 | O. W. Pflasterer | Medicare Weaknesses, Fallacies & Liabilities Reinforcing Opposition to Compulsory Federally Mandated Health Insurance | Referred to B of T |
| 77N-18 | O. W. Pflasterer | Tax Credits for Medical Expenses | Substitute adopted |
| 77N-19 | O. W. Pflasterer | Shortcomings of Medicare and Public Aid Projected to National Health Ins. | Referred to B of T |
| 77N-21 | O. W. Pflasterer | Opposition to Federally Mandated Compulsory National Health Insurance | Adopted |
| 77N-31 | Donald Quinlan | National Health Insurance | Rejected |
| 77N-32 | Donald Quinlan | National Health Insurance | Rejected |
| 77N-49 | Robert L. Prentice | Comprehensive Health Care Insurance Act HR 1818 and S 18 | Referred to Governmental Affairs Council |

# CME REGULATIONS

Rule XI, the new section of Rules and Regulations for administration of the Medical Practice Act, is published below in its entirety. This was developed pursuant to Section 5.1 of the Act, enacted by the General Assembly, which mandates CME and was signed into law in 1976.

Several items are called to your attention.

First, categorization of medical education activities into Category 1 or 2. Category 1 includes formal learning programs, verified teaching, or recognized patient care audit activities as detailed below. (See Article II, Section 1). Category 2 includes verified or verifiable activities in (a) specialty society & other professional organization meetings; (b) teaching rounds, grand rounds, lectures & hospital departmental & scientific meetings; (c) formal learning experiences in subjects not directly related to clinical medicine, but which facilitate physician performance —such as programs in computerized patient record systems, health administration, education, etc.; (d) papers published & delivered before specialty societies or presented in nationally-recognized medical journals and (e) verifiable self-instruction, including use of teaching devices & medical literature. Category 1 credit can be used to satisfy Category 2 requisites. (See Article II, Section 1).

Second, one should note the establishment of a pre-renewal period. Licenses are renewable as of July 1, each even numbered year. A 24 month pre-renewal period ending the previous March 31 has been established as the time during which CME must be accomplished for qualification. Renewal notices will be sent to registrants in April and this will allow sufficient time for the Dept. of Registration and Education to perform any audits it deems necessary. (See Article I, Section 1 (b)).

Third, please note the requirement of 100 hours of CME for each renewal. At least 50 of these must be in Category 1. Of these 50 hours, at least 20 must be part of an approved, formal educational program as specified below. The balance may fall into the realm of approved teaching or medical-care audit activities. (Article I, Section 2, and Article II, Section 1.)

In cases of noncompliance or requests for exemptions, the regulations outline procedures for hearings before the Medical Examining Committee. The Committee then would make recommendations to the Director of R&E who has final responsibility for licensing matters.

Finally, it should be noted that since the first pre-renewal period expires March 31, 1978 and since the new Rule is effective January 1, 1978, only a pro-rated number of hours (12) are required, 4 of which must be in Category 1. However, the full 24 month pre-renewal period (April 1, 1976 through March 31, 1978) is applicable for accumulating the required hours.

On license renewal forms, which will be sent out about April, 1978, the applicant will be asked to check a box signifying compliance. The department may require verification through an audit of CME accomplished.

## RULE XI
## CONTINUING MEDICAL EDUCATION

**Forward:**

This RULE is promulgated pursuant to Section 5.1 of the Medical Practice Act, approved June 20, 1923, as amended ("the Act"), and in conformity with the requirements of that Section with respect to mandatory continuing medical education (hereinafter called "CME") for persons licensed in Illinois pursuant to the Act.

### ARTICLE I. BIENNIAL RENEWAL OF LICENSE

*Section 1.* The commencement date of the next renewal period for which licenses to practice medicine in all of its branches or to treat human ailments without the use of drugs or medicines and without operative surgery is July 1, 1978. At the time a person applies to the Department of Registration and Education of the State of Illinois ("Department") for renewal of the license to him or her pursuant to the Act for the renewal period commencing July 1, 1978 ("first renewal period"), or for any renewal period after June 30, 1980, such person ("renewal applicant" or "applicant") shall, subject as hereinafter provided, submit to the Department evidence, on forms supplied by the Department, of his or her CME:

(a) During the period commencing January 1, 1978, and ending March 31, 1978, in the case of applications for renewal for the first renewal period and thereafter

(b) During any period of 24 calendar months immediately prior to April 1 in the year in which will occur the commencement date of the period for which renewal of such license is sought. (The period of 24 calendar months immediately prior to the April 1 in which will occur the commencement date of the renewal period for which renewal of such license is sought is hereinafter sometimes called "prerenewal period.")

*Section 2.* The Department shall require 100 credit hours of CME relevant to the practice of medicine in all of its

branches or the practice of any system or method of treating human ailments without the use of drugs or medicines and without operative surgery, as the case may be, for which such applicant holds a license issued by the Department, such credit hours to be distributed, except as hereinafter in this Section 2 stated, over a period of two years, and in any category or categories hereinafter designated, all as such applicant may elect, during the applicable prerenewal period; provided that, anything herein to the contrary notwithstanding, for the prerenewal period ending March 31, 1978:

(a) Each applicant should be required to have a total of 12 credit hours (equavilent to an average of 4 credit hours of CME for each full calendar month during the period commencing January 1, 1978, and ending March 31, 1978), and the same may be distributed as the applicant may elect, subject as provided in the immediately succeeding subdivision (b) and

(b) Each applicant shall be required to have, and include, as part of the CME required hereunder, during the period commencing January 1, 1978, and ending March 31, 1978, both dates inclusive, at least one-third of the required CME credit hours (i) in the Category described in Section 1 of ARTICLE II as CATEGORY 1 or (ii) in the Category described in Section 3 of ARTICLE II as CATEGORY 1. The total number of required hours of CME, or any part thereof, may have been earned at anytime during the period of 24 months prior to April 1, 1978.

## ARTICLE II. CATEGORIES OF CME FOR WHICH CREDIT SHALL BE AWARDED

*Section 1.* Activities approved by the Department for which CME credit may be earned by each person licensed to practice medicine in all of its branches during each prerenewal period are as follows:

### CATEGORY 1

A minimum of 50 hours—up to the full 100 hours—in formal learning programs as defined in (a) below or by either or both teaching and medical care evaluation activities as defined in (b) below or in compliance with requirements equivalent to those provided by the applicable Illinois statutes or rules or regulations with respect to requirements of the kind hereinafter set forth in Section 2 of this Article II:

(a) At least 20 hours of verified attendance at any formal education program which is sponsored or cosponsored by an organization accredited for CME by American Medical Association ("AMA") prior to July 1, 1977, or accredited on or after July 1, 1977, by the Liaison Committee on Continuing Medical Education ("LCCME") or by the Committee on Continuing Medical Education of the American Osteopathic Association or by any other agency or institution recognized or accepted by the Department for the provision of continuing medical education, all subject to such further determination or determinations as may be made by the Department at any time or from time to time.

(b) Up to 30 hours of all or any verified teaching of medical students, postgraduate medical trainees, or of verified teaching of preceptees or practicing physicians in CME programs sponsored or cosponsored by any organization, agency or institution referred to in the immediately foregoing subparagraph (a) of this Category I or of verified participation in the activities of a medical audit, patient-care evaluation, utilization review committee or similar committee of a hospital licensed by the Illinois Department of Public Health; or verified participation in patient-care review activities of a Professional Standards Review Organization or other regional agency authorized by State or Federal law to monitor the quality of medical care; or verified participation in patient-care review activities of a medical foundation or other physician-organized or sponsored agency established voluntarily to monitor the quality of medical care, which such foundation or such other organization is approved by the Department.

### CATEGORY 2

Up to 50 hours of:

(a) Verified attendance at, or participation in, meetings of recognized specialty or professional organizations, teaching rounds and exercises in postgraduate programs heretofore approved by the Liaison Committee on Graduate Medical Education ("LCGME"), or by the Committee on Continuing Medical Education of the American Osteopathic Association;

(b) Verified attendance at lectures, grand rounds, departmental or hospital scientific meetings, and similar activities in LCCME accredited hospitals which are not organized as formal education programs of the kind referred to in CATEGORY 1 of this Section 1 of ARTICLE II;

(c) Verified formal learning experiences sponsored by recognized agencies not accredited for CME, but approved by the Department, in subjects not directly related to clinical medicine that facilitate physician performance, such as courses in computerized patient-record systems, or training—including advanced degree programs—in education, health administration, and similar subjects;

(d) Papers prepared and delivered before recognized specialty societies, papers published in nationally recognized medical journals, or a chapter in a medical book, or an exhibit prepared for a medical meeting, each appropriately verified; and

(e) Up to 50 hours—in verified self-instruction—individual use of audio-visual materials, use of teaching devices, and study of medical literature—which is sponsored or cosponsored by any recognized medical college, institution or national, state or local medical association, or national specialty society, or organization similar to any of the foregoing.

(f) Any excess credit hours earned under Category 1, paragraph (b) can be used to satisfy Category 2 requirements.

*Section 2.* Additional activities approved by the Department for which CME credit may be earned by any person licensed to practice medicine in all of its branches during each pre-renewal period are as follows:

Up to the full 100 hours—in, or toward, verified compliance with any of the following requirements, provided that the applicable specific requirements, in each case, are substantially equivalent to, or greater than, those imposed by the applicable Illinois statutes or by these or any other applicable governmental rules or regulations:

(a) CME requirements of another state medical licensing authority;

(b) Certification or Recertification by a specialty board;

(c) CME requirements of a national specialty society; or

(d) Six months or longer, working full time in a residency program approved by the LCGME or in a postresidency fellowship,

all subject to the approval of the Department.

*Section 3.* Applicants who are licensed to practice a system or method of treating human ailments without the use of drugs or medicines and without operative surgery may earn CME credit during each prerenewal period for activities hereinafter set forth in this Section and then only to the extent stated:

## CATEGORY 1

(a) A minimum of 50 hours—up to the full 100 hours—in verified attendance at any formal education program which is sponsored, cosponsored or accredited by:
  (i) any chiropractic institution having approved status with the Council on Chiropractic Education approved by the Department or any chiropractic school or other chiropractic institution approved by the Department; or
  (ii) American Chiropractic Association or International Chiropractic Association, or any of their respective Council and Diplomate programs; or
  (iii) Illinois Chiropractic Society or Prairie State Chiropractic Association, or any of their respective local chapters;

  all subject to such further determination or determinations as may be made by the Department at any time or from time to time.

(b) Up to 30 hours of all or any verified teaching of chiropractic students, or postgraduate chiropractic trainees, or of verified teaching of preceptees or practicing chiropractors in CME programs sponsored or cosponsored by any organization referred to in the immediately foregoing subparagraph (a) of this Category 1.

(c) Up to the full 100 hours—in, or toward, verified compliance with any of the following requirements, during each prerenewal period, provided that the applicable specific requirements, in each case, are substantially equivalent to, or greater than, those imposed by the applicable Illinois statutes or by these or any other governmental rules or regulations:
  (i) CME requirements of another state licensing authority with respect to chiropractors;
  (ii) Certification or Recertification by a specialty board;
  (iii) CME requirements of national chiropractic specialty society; or
  (iv) Six months or longer, working full time in a residency program approved by the Council on Chiropractic Education, or in a post-residency fellowship; or
  (v) attendance at programs of the kind referred to in subparagraph (a) of CATEGORY 2 of Section 1 of ARTICLE II.

## CATEGORY 2

Up to 50 hours of any or all of the following:

(a) Verified self-instruction—individual use of audiovisual materials, use of teaching devices, and study of chiropractic or medical literature—which is sponsored or cosponsored by any institution or other organization hereinbefore referred to in subparagraph (a) of CATEGORY 1 of this Section 3 of ARTICLE II; and

(b) Papers prepared and delivered before recognized specialty societies, papers published in nationally recognized medical or chiropractic journals or a chapter in a chiropractic book or any exhibit prepared for a chiropractic meeting, each appropriately verified.

*Section 4.* Where any of the activities hereinbefore described is required by the terms hereof to be verified, the applicant may satisfy such requirement by the performance thereof and the filing with the Department of a statement under oath describing the particular activity or activities for which CME credit is at any time claimed with such particularity as shall be satisfactory to the Department, subject to the right of the Department to require further details with respect thereto in such form as the Department shall specify.

*Section 5.* One clock hour substantively spent satisfying the requirements of CATEGORY 1 or 2, or any part thereof, of Section 1 of ARTICLE II, or of Section 2, or any part thereof, of ARTICLE II or of CATEGORY 1 or 2, or any part thereof, of Section 3 of ARTICLE II shall equal one credit hour for the purpose of satisfying the CME credit-hour requirements hereof during any prerenewal period.

*Section 6.* Hospitals, organizations, associations, councils, committees, societies, colleges, schools, institutions or other entities (hereinafter called, individually, "sponsor") as a condition to being approved, or continuing to be approved, or having activities accepted by the Department, for CME credits which may be earned by renewal applicants in order to comply with CME requirements herein stated, shall at all times:

(a) Maintain accurate records of the names and addresses of all renewal applicants attending or participating;

(b) Record accurately in such records the exact number of hours of such attendance or participation, or both, by each renewal applicant;

(c) Issue to each renewal applicant a certificate certifying the exact number of hours of attendance or participation or both, signed by the registrar or other authorized officer of such sponsor; and specify that such certification is subject to the terms of this Section 6 of this ARTICLE II;

(d) Make available to any renewal applicant who, in any way, has attended, engaged or otherwise participated in any CME activities under the auspices of such sponsor and paid in full all tuition or other fees therefor, or to anyone designated by such applicant, the records or pertinent part thereof, requested by such applicant, for examination and audit during the regular office hours of such sponsor; and

(e) Maintain records in compliance with all applicable accreditation requirements.

Upon the failure of any sponsor to comply with any of the foregoing requirements, the Department, after notice to such sponsor and hearing before, and recommendation by, the Medical Examining Committee, may refuse to accept any such attendance or participation in any CME activities, courses or programs sponsored or cosponsored as in compliance with CME requirements under this RULE XI and may, by reason of such failure, thereafter refuse to accept, for CME credits, attendance or participation in, any such sponsor's CME activities, courses or programs until such time as the Department receives reasonably satisfactory assurances of compliance with this Section and all other applicable provisions of this Rule XI.

## ARTICLE III. CERTIFICATION OF COMPLIANCE WITH CME REQUIREMENTS

*Section 1.* Each application for biennial license renewal shall be under oath. Each renewal applicant shall, except as provided in Section 3 of this ARTICLE III and in ARTICLE IV of this RULE, certify, on such license renewal application, to such applicant's full compliance with the CME credit-hour requirements set forth in ARTICLE I of this RULE during the pertinent prerenewal period by marking an "X" or check mark in a box provided for such purpose or by so certifying in any other way which shall be satisfactory to the Department.

The Department may, but shall not be required:

(a) To set forth on such application the question: Has the applicant fully complied with the valid applicable CME requirements for the renewal of such applicant's license which this application seeks? and

(b) To provide such applicant with the opportunity to make an affirmative answer on such application in any of the ways hereinbefore provided in this Section.

*Section 2.* The Department relies upon each individual applicant's integrity in certifying to such applicant's compliance with the CME requirements herein provided. Nevertheless, the Department reserves the right to require, if it so elects, any renewal applicant to submit, in addition to such renewal application, further evidence satisfactory to the Department demonstrating compliance with the CME requirements herein provided. Accordingly, it is the responsibility of each renewal applicant to retain or otherwise be able to have, or cause to be made, available, at all times, reasonably satisfactory evidence of such compliance.

*Section 3.* Any applicant who is first licensed in Illinois by examination after the effective date of this RULE, shall not be required to comply with any CME requirements herein set forth for the first renewal of such applicant's license.

*Section 4.* In the event that the Department shall find, with respect to any application for license renewal and any other evidence of compliance with the CME requirements of this RULE submitted to it by any renewal applicant that:

(a) Such application or any further evidence of compliance with the CME requirements herein provided for are, for any reason, unsatisfactory to the Department, whether because the Department has questions or doubts with respect to any matters set forth in such application or such further evidence, or both, or for any other reason whatsoever, or

(b) The Department has no satisfactory evidence demonstrating that such applicant has complied with the CME requirements provided by this RULE after requesting such applicant to furnish or otherwise provide such evidence,

the Department shall give to such renewal applicant personally or by written notice, by registered or certified mail, return receipt requested, addressed to such applicant at the address to which such applicant's last renewal application was addressed or any subsequent address furnished by such applicant, of (i) such finding, (ii) its proposed recommendation to the Director on the basis of such finding, and (iii) the date and place of hearing before the Medical Examining Committee. At such hearing such applicant shall have an opportunity to be heard with respect to such finding and proposed recommendation and to present evidence satisfactorily showing full compliance with the applicable CME requirements of this RULE or reason for waiver of such requirements, or any of them. Such applicant or the Department may have, if either party so elects, a stenographer present at such hearing to take down any testimony given thereat and preserve a record thereof, all at the expense of such applicant. After considering, also, such further evidence relating to the matters set forth therein as shall have been filed with the Department by such renewal applicant or, after reasonable notice to the applicant, by anyone else or presented at such hearing, the Medical Examining Committee shall present to the Director a written report of its findings and recommendations as to whether such applicant has satisfied, during the prerenewal period involved, the requirements of this RULE with respect to the relevant CME requirements, or reasons for waiver of such requirements, or any of them, and, accordingly, whether such applicant's application for renewal of license should be granted. A copy of such report shall be served upon such renewal applicant either personally or by registered or certified mail addressed as aforesaid. Within 20 days after such service, such renewal applicant may present to the Department his or her written motion for a rehearing, if desired, and shall specify the particular grounds therefore.

## ARTICLE IV. WAIVER OF CME REQUIREMENTS AND EXTENSION OF TIME WITHIN WHICH TO COMPLY

Any renewal applicant seeking renewal of license without full compliance with these CME requirements with respect to having the required number of credit hours of CME shall file with the Department application for license renewal, the required fee therefor, an affidavit setting forth the facts concerning such noncompliance, and a request for waiver of the CME requirements on the basis of such facts. Thereupon, if from such affidavit or any other evidence submitted, each case being considered by the Medical Examining Committee, on an individual basis, and upon written report and recommendation of the Committee, the Department finds:

(a) That, during the applicable prerenewal period, there was an absence of opportunities for CME in the locality or localities in which such renewal applicant was engaged in the lawful practice of the licensed profession during such prerenewal period and that the absence of such opportunities would interfere with the adequacy of medical services in such locality or localities, or

(b) That good cause, as hereinafter defined, has been shown for granting to such renewal applicant an extension of time within which such applicant shall complete compliance with all such CME requirements or any part thereof with which such applicant has not complied,

the Department:

(i) In the case of situations involving item (a), shall waive the enforcement of such CME requirements and renew such license for the renewal period for which such applicant has applied and

(ii) In the case of situations involving item (b), shall specify the length of the extension of time granted, if any, within which such renewal applicant shall

complete compliance with all such CME requirements and during which period of extension such renewal applicant may continue to practice, subject as hereinafter provided, and shall notify such applicant thereof.

Good cause shall be, but is not limited to, any of the following:

(a) serving full time in the regular armed forces of the United States of America during any part of the applicable prerenewal period.

(b) inability to devote sufficient hours during the applicable prerenewal period to CME because of illness, incapacity, undue hardship or any other extenuating circumstances.

Any waiver of, enforcement of, or extension of time granted for, compliance with such CME requirements shall be without prejudice to the Department's power or right to refuse license renewal at any time or from time to time for any renewal period for which application is filed or for any remaining balance of such period because of noncompliance with CME requirements during any prerenewal period or any other proper ground for such refusal.

Hearing before the Medical Examining Committee with respect to any request for such waiver may be granted only if such hearing is requested at the time the request for such waiver is filed with the Department. The renewal applicant requesting such waiver shall be given at least 20 days written notice of the date, time and place of such hearing by certified mail, return receipt requested.

## ARTICLE V. NONCOMPLIANCE WITH THIS RULE XI

In the event that any renewal applicant becomes ineligible for license renewal because of failure to comply with any of the provisions of this RULE XI such applicant's license shall not be renewed pursuant to the renewal application theretofore filed by such applicant or pursuant to any other renewal application at any later time filed by such applicant and shall expire, subject to reinstatement as hereinafter in this ARTICLE V provided. The Medical Examining Committee may recommend to the Director the reinstatement of any such applicant whose license has expired upon receipt of satisfactory evidence that such applicant or licensee has corrected any deficiency in the required credit hours of CME and is then in all other respects in compliance with this RULE and the Act.

## ARTICLE VI. CONFIDENTIAL INFORMATION

Information which in any way relates to the CME of any licensee under the Act or the participation of such licensee therein, as same pertains to any aspect of such licensee's practice liability, public image or relationships with individual patients, shall be deemed strictly confidential, except that such information which may, at any time, be in the Department's files or other records may be made available:

(a) Upon written consent of such licensee or, in case of such licensee's death or disability, of such licensee's personal representative; or

(b) At any hearing in which the Department or its Director or any other personnel of the Department, or the Medical Examining Committee, or the Medical Disciplinary Board shall be involved or otherwise interested; or

(c) At any court or administrative proceeding or at the taking of testimony, whether orally or by deposition, or both, in connection with any such proceeding, in which the Department or its Director or any other of its personnel shall be served with a subpoena or a subpoena duces tecum, as the case may be, of a court or administrative body of competent jurisdiction upon payment of the same fees and mileage as prescribed by law in the case of judicial proceedings in civil cases in Illinois courts.

---

# *EKG*

*(Continued from page 6)*

**Answers: 1. B,C,D. 2. E.**

The ECG lead II rhythm strip shows sinus rhythm with a short PR interval. The QRS is normal in duration. The first, fifth, and eighth beats in the first line are followed by inverted P waves which distort the T wave and reset the sinus cycle. These are retrograde P waves. The fourth beat in line 2 and the ninth beat in line 3 are echo or reentry beats. In these two beats the R-P interval is slightly longer than the R-P intervals where no echo beat is seen conducted back to the ventricles. The Q-T interval is at the upper limits of normal and the T wave shows a morphological change in the beats after the long cycles (post-extrasystolic).

The mechanism of the tachycardia is felt to be reentry or a circus movement over two pathways between the atria and the ventricles. In this case the short PR interval could represent conduction time over the bypass tract and the R-P interval could represent retrograde conduction through the A-V nodal-His system. Reentry tachycardias require electrophysiologic inhomogeneity to allow for this circus movement. Propranolol is useful here because it can prolong the conduction times and so prevent the tachycardias from starting. For further reading on this subject see Josephson: *American Journal of Cardiology*, 40:521, October, 1977.

# *Abstracts of Board Actions*

*(Continued from page 11)*

## Computer Second Opinion

In response to critics, the Board of Trustees will retain an outside firm—not previously associated with the Society—to evaluate the ISMS computer unit. The analysis will seek to determine the: (1) Efficacy of the computer in terms of hardware and software costs; (2) Potential for ISMS personnel to operate the system by July 1, 1978, or sooner, independent of outside computer managers currently employed; and (3) Unit's capacity to meet added needs of the Medical Society and the Insurance Company as currently foreseen. Bids for the analysis will be sought from at least two firms at a cost not to exceed $8,000. The Board of Trustees authorized the lease/purchase of the computer unit in January, 1976, following a three month investigation of the need for a computer to support the Society's insurance needs. The controversy originated over misconceptions as to the relationship of this computer unit to the data needs of the state and local medical care foundations.

## Medicaid Issues

ISMS will submit to Gov. Thompson and the General Assembly recommendations designed to ensure that IDPA's audit rules and regulations are administered in a manner that effectively controls fraud, but also defines reasonable standards and affords due process.

The Society also will formally protest to IDPA Director Arthur Quern the Department's violation of an August, 1977, commitment to implement an effective review of psychiatric Medicaid benefits and to increase current length-of-stay allowances for psychiatric patients.

## Workman's Compensation Insurance Plan

ISMS will make available to members a Workman's Compensation Insurance Plan through the Dodson Insurance Group of Kansas City, Missouri. Details will be mailed to all members.

## National Guidelines for Health Planning

ISMS will submit written testimony to HEW on the proposed National Guidelines for Health Planning, focusing upon these major objections:

- Guidelines violate the concept of "grass-roots planning" by mandating that Health Systems Plans, Certificate of Need Programs, State Health Plans and Medical Facilities Plans be consistent with the National Guidelines.
- Guidelines restrict the practice of medicine by setting unrealistic constraints that will reduce the availability of health services.
- Since the Guidelines are to be universally applied to all facilities and areas throughout the country, HEW has not realistically assessed their potential impact on the financing or delivery of health services.

## Minimum Standards for Health Insurance

The following revisions were made in the Society's Minimum Standards for Health Insurance:

- Major Medical: The number of visits for "physician-performed" psychiatric treatment "should not be rigidly limited," and all should be paid at least 80% UCR.
- Basic Coverage: Visits for psychiatric care should be expanded to 20% per year, paid at 80% UCR.

ISMS will publicize the availability of the "Minimum Standards" to labor, business and professional organizations. These groups frequently request recommendations concerning appropriate health insurance benefits.

## Task Force on Cost Effectiveness

The Task Force on Cost Effectiveness—created by the Board of Trustees last April to identify and ameliorate the root causes of spiraling health costs in Illinois—was authorized to pursue these objectives:

- Educate and establish credibility with labor, management, media and legislators through a conference or series of meetings with their leaders.
- Inform hospital boards, staff and physicians of various cost containment efforts perfected by their hospital as well as other institutions.
- Educate the public on various cost-saving efforts already perfected by the health care industry and convince them of their personal obligations to prevent illness and control costs.

The Task Force is composed of representatives of ISMS, Chicago Medical Society, Illinois Hospital Association, Chicago Hospital Council and Blue Cross/Blue Shield.

As a step toward meeting its first objective—to educate and establish credibility with labor, management and legislators—the Task Force will hold a half-day conference early next year with leaders of these groups. Expenses will be shared equally by organizations comprising the Task Force.

## Establish Illinois Medical Journal Editorial Board

An eight-member editorial board will be established for the Illinois Medical Journal (IMJ), replacing the position of IMJ editor. The editorial board—functioning under the Publications Committee—will be responsible for IMJ content and editorial philosophy.

In other action concerning IMJ, the Board:

- Authorized for one year a special advertising package featuring a 50 percent reduction in color ad rates. The package will apply to color ads purchased for joint publication in IMJ and other state journals represented by the IMJ space sales firm.
- Approved a copyright statement allowing photocopying of IMJ materials for non-commercial scientific or educational advancement.
- Authorized acceptance of directory-type professional classified ads in IMJ's classified section, subject to review and approval by the Publications Committee keeping with standard procedures.

## Co-Sponsor Program on Pollution

ISMS will co-sponsor an AMA program next spring on "How Air Pollution Affects Medical Care." An ad hoc committee—composed of ISMS Council on Medical Service members and outside consultants—will participate in program planning and implementation. The session will be designed for private practitioners, academic and public health physicians. Proceedings from programs—along with those from similar sessions in other states—will be used to develop a resource book on the subject. AMA will assume all major costs, with ISMS assisting in planning, implementing and promoting the program in Illinois.

## Guidelines for Use of Oxytocin-Type Drugs

The Board adopted guidelines for use of oxytocin-type agents and will urge the Illinois Department of Public Health to incorporate them into its regulations. The guidelines were formulated in response to an IDPH request to review regulations governing use of oxytocin

## Recommend Choke-Saving Method

The Illinois Department of Public Health will be urged to adopt and publicize the "Heimlich Maneuver" as its approved method of choke-saving. Recently-enacted legislation directed IDPH to adopt an approved choke-saving method that could be used by the general public, and the IDPH solicited an ISMS recommendation.

## Scoliosis Screening Programs

ISMS will initiate a meeting of individuals and groups involved in scoliosis screening to determine how screening can be made available throughout the state. Several screening programs currently are conducted by professional, educational and governmental groups. Last April, the Board encouraged scoliosis screening in all Illinois school districts. Subsequently, the Illinois Office of Education requested ISMS assistance in implementing a statewide screening program.

## School Health Code Revisions

ISMS will support—in the next legislative session—proposed IDPH revisions in the School Health Code. The IDPH proposal covers the Code, examination forms and guidelines.

## Nursing Home Inspections

The following position was adopted concerning multiple inspections of local nursing homes by state and federal agencies:

> Examination of patients by governmental inspection teams should be conducted only when prior permission has been given by the patient, the patient's physician or the nursing home. No examination should be done without a nurse or physician present.

The position will be forwarded to all governmental agencies conducting nursing home inspections, along with a recommendation that inspections be combined whenever feasible.

## Emergency Medical Information Card

The Board approved in principle a plan to assist the Illinois Secretary of State with implementation of ISMS-backed legislation directing the Secretary to allocate space on the driver's license for a symbol indicating that the driver is carrying Emergency Medical Information (EMI). ISMS will: (1) Urge the Secretary to adopt an ISMS-modified version of AMA's EMI card; (2) Offer to produce the cards as a public service; (3) Urge the Illinois Department of Public Health and the Secretary to use the universal EMI symbol as the official driver's license sticker; and (4) Urge the Secretary to encourage drivers to have their physician complete the EMI card. The Society will consult with the Secretary of State to devise a method of distributing the EMI cards.

## Amendments to Immigration and Nationality Act

ISMS will solicit comments from training directors of Illinois hospitals and other appropriate institutions regarding proposed amendments of the Immigration and Nationality Act Affecting The Entry of Alien Physicians into the United States. Training directors will be provided with information supplied by the Educational Commission for Foreign Medical Graduates and asked to comment on how they would be affected by the legislation. Replies will be considered in developing an ISMS position statement.

## IDPA Drug Manual

The following drugs were approved for inclusion in the IDPA Drug Manual: Lorelco, Tagamet (brand of Cimetidine), Norpace, Colestid, Flexeril, Pamelor (automatic under Nortriptyline HCL), Ascodeen-30, Tears Naturale, and Ativan.

## Appointments & Elections

Dr. Robert Hamilton, Chicago, was designated as a replacement for Dr. Charles Schlageter, Chicago, on the Board of Directors of the Illinois State Medical Insurance Services. In a related action, the Board of Governors of the Illinois State Medical Inter-Insurance Exchange elected Drs. Irwin Smith, Northbrook, and Thomas Moore, Elmhurst, to the ISMIE Board.

Dr. Harold Lasky, Chicago, was appointed to the ISMS Board of Trustees replacing Dr. Alfred Faber, Northbrook, who resigned as Third District Trustee. Other appointments included:

- *Medical Legal Council*—Dr. Donald Aaronson, Chicago
- *Council on Governmental Affairs*—Dr. Linda Hughey, Wilmette
- *Council on Public Relations*—Dr. Ira Isaacson, Chicago
- *Council on Mental Health & Addiction*—Dr. Jesse Biner, Chicago
- *Council on Education & Manpower*—Dr. Anthony Savino, Oak Park
- *Committee on Physician Assistants*—Drs. Joseph Bordenave, Geneva; Joseph Garfunkle, Springfield; and Charles McHugh, Chicago
- *ISMS Representative to the Illinois Cooperative Health Data System, Inc.*—Dr. Henrietta Herbolsheimer, Chicago, replacing Dr. Phillip Boren
- *ISMS Representative to the Gerontology Task Force of Sangamon State University*—Dr. Shirley Roy, Chicago

---


**The University of Illinois at the Medical Center announces**

**PRIMARY CARE AROUND THE WORLD**

**an international study tour planned with the assistance of the World Health Organization**
**September 19 – October 10, 1978**

**Switzerland • Iran • Israel • Yugoslavia**

This three week *interprofessional* study tour is designed to provide, for a small group of participants, an opportunity to gain greater familiarity with patterns of primary health care used abroad that may also be useful in the United States. The tour will begin at the World Health Organization Headquarters in Geneva, Switzerland, with seminars conducted by WHO staff. The group will then travel to primary care delivery and training sites in Iran, Israel, and Yugoslavia before returning to Geneva for a summary meeting. This educational opportunity promises to provide new perspectives for health professionals involved in the organization, administration, teaching or delivery of primary care.

The cost — approximately $2,000.00 — includes round trip air transportation, first class hotel accommodations, continental breakfasts, and preparatory study materials. The seminar group will be limited to 30 participants.

**For detailed itinerary and further information contact:**
**University of Illinois at the Medical Center • Office of Continuing Education Services**
**1853 West Polk Street, Room 144 • Chicago, Illinois 60612 • (312) 996-8025**

*This is the first in a series of traveling seminars planned in collaboration with the World Health Organization. Future seminars will focus on primary care in Latin America, Scandinavia, the Far East, and Eastern Europe.*

# Physician Recruitment Program

*In an effort to reduce the number of towns in Illinois needing physicians, the Physician Recruitment Program and the Doctor's Job Fair, are publishing synopses in the Journal.*

*Physicians who are seeking a place to practice or who know of any out-of-state physicians seeking an Illinois residence are asked to notify the Program.*

*Any areas wishing to be listed should contact: Mrs. E. Duffy, Physician Recruitment Program, ISMS, 55 E. Monroe, Suite 3510, Chicago, 60603.*

**CAIRO:** PADCO Community Hospital seeking licensed physician for Emergency Room and Outpatient Department practice. Special consideration for physician experienced in working with physician's assistant. Guaranteed salary plus incentive bonus, fringe benefits and all supportive requirements provided. Rural community with excellent recreation opportunities. Medical staff privileges with general and specialty staff. Contact Harvey H. Pettry, Administrator, PADCO Community Hospital, 2020 Cedar Street, Cairo, Illinois 62914. Call collect-618/734-2400. Equal opportunity employer. (2)

**CAIRO:** Small Southern Illinois Hospital seeking two (2) Family Practice or General Practice physicians with present Illinois license or reciprocity status. Rural practice. Excellent salary guaranteed, fringe benefits. Office expenses and malpractice paid. Hospital will help one physician recruit second physician. Call 618/734-2400 or write Harvey H. Pettry, Administrator, PADCO Community Hospital, 2020 Cedar Street, Cairo, Illinois 62914. Equal opportunity employer. (2)

**CHICAGO:** General Surgeon—group located in 300-bed hospital in Chicago has an immediate opening for a general surgeon. Excellent benefits and salary. Reply to Box JP, c/o Physician Recruitment Program, 55 E. Monroe, Chicago, IL. 60603. (4)

**CHICAGO:** Group practice requires American educated and trained surgeon (general). Board certified or eligible. Practice affiliated with up to date medical center facility. Respond in confidence: Box EH, Physician Recruitment Program, ISMS, 55 E. Monroe, Chicago 60603. (2)

**CHICAGO:** HALF-TIME EMPLOYEE HEALTH SERVICE PHYSICIAN: For progressive 372-bed university affiliated hospital, located on Chicago's northern lakefront. This is a part-time position, Monday-Friday, with the hours divided between the morning and afternoon. Excellent opportunity to initiate programs and provide leadership in developing a more comprehensive Health Service. Private Practice potential with office space, and teaching opportunities are also available. Candidates interested in pursuing this position further are invited to call or write to: Nancy Siegel, Staffing Specialist, Louis A. Weiss Memorial Hospital, 4646 N. Marine Drive, Chicago, Illinois 60640, (312) 769-2162. (2)

**CHICAGO:** Dr. Charles Chadbourn is looking for a doctor to take over practice immediately. Practice consists of obesity, industrial, some private and public aid patients. 7948 S. Western Ave. Call Marilyn at 436-2552 for appointment. (5)

**DeKALB:** Northern Illinois University. Need internist and chief of clinical medicine, psychiatrist and head of mental health, and primary care physicians. Competitive salaries, fringes, 9- or 12-months annual contract, good facilities, 21,200 students, near metropolitan Chicago. Contact L. W. Akers, M.D., University Health Service, NIU, DeKalb, Ill. 60115. AA/EOE Employer. (5)

**ILLINOIS:** The Illinois Department of Mental Health and Developmental Disabilities has opportunities in all areas of the State for psychiatrists and primary care physicians. M.D.'s and O.D.'s with Illinois licensure will be considered. Salaries competitive commensurate with training and experience; attractive fringe benefits. Contact John T. Nelson, M.D., Coordinator of Medical Affairs, 750 South State Street, Elgin, Illinois 60120. (312-793-2730) (5)

**JOLIET:** Illinois Community Needs Family Doctor. We have a new pharmacy and a clinic waiting for you. No MDs in this city of 5,000—with 15,000 population base. In-house X-ray facilities. Sixty miles south of Chicago off I-55; 20 miles southwest of Joliet. Six hospitals within 20 minutes and full service pharmacy next door. Negotiable guarantee. Ron Radley, 815-458-2224 or 634-4900. (3)

**MUNSTER:** Industrial and Emergency Room physician needed for large midwest multispecialty clinic. Trauma oriented physician only need apply. Competitive first year salary with opportunity for early equal Partnership in 60 man group. All fringes clinic paid—most liberal vacation and PG allowance. No investment required. Send CV to: Thomas R. Hofferth, Hammond Clinic, 7905 Calumet Ave., Munster, IN 46321. (219) 836-5800 (5)

**PITTSFIELD:** Family practitioners and surgeons interested in locating in rural community area needed. Population 4100; area 18,000. Excellent opportunity for some one wanting to practice in a rural community. Located between Jacksonville, Illinois and Quincy, Illinois on Highways 54 and 36. Contact Mr. Gary Deer, 217-285-2113. (5)

**ROCKFORD:** Psychiatrist, Board Certified or Board eligible with intention to obtain certification wanted for dynamic, growing corporate practice in Illinois' second largest city. Contact: Brian E. Tugana, M.D., Institute for Mental Sciences, 5670 East State Street, Rockford, IL 61108—(815) 397-3177. (2)

# CLASSIFIED ADVERTISING

## POSITIONS & PRACTICE OPPORTUNITIES

**OB-GYN, ENT, PEDIATRICS, SPECIALISTS** needed by 16-man multi-specialty clinic in university community of 50,000 in western Wisconsin; excellent retirement and fringe benefits; fine recreational opportunities; salary negotiable. Send curriculum vitae and references to: John R. Ujda, M.D., La Crosse Clinic, 212 South 11th Street, La Crosse, Wisconsin 54601.

**NEONATOLOGIST** to join 10 member Pediatrics Division of a 100 doctor multispecialty clinic with adjacent hospital; located in 8ig 10 University community of 100,000; large referral practice, as well as primary care; new medical school offers opportunity for teaching; hospital has just under 1000 deliveries per year with 13,000 per year in area without designated center; O8/Pediatrics Departments are requesting state designation as perinatal center with completion in early 1977 of excellent new hospital, L & D, NICU facilities. Contact Medical Director, Carle Clinic, Urbana, IL 61801.

**FULL TIME PHYSICIAN** for Industrial Clinic in Skokie. Surgical experience needed. Salary negotiable. Must have Illinois license. Call (312) 674-4800, Mrs. McCubbin.

**AN ASSOCIATE NEEDED** for prosperous otolaryngology and maxillofacial surgery practice in Chicago. To eventually take over practice. University affiliation possible. Send curriculum vitae to 8ox 899, Illinois Medical Journal, 55 E. Monroe, Suite 3510, Chicago, 60603.

**F.P.'s NEEDED**—Growing community of 4000+ needs 1-2 M.D.'s. 2 F.P.'s in town & 1 near by. Join existing practice or solo available. Excellent recreation & econ. 60 miles from metro-cities, 57 8ed J.C.A.H. Hospital in community. Trade area of 12,000+. U.S. Graduate preferred. Contact L. Wattier, Adm., Mem. Hosp. Inc. 104 W. 17th, Schuyler, NE 68661 (402) 352-2441

**ILLINOIS REGISTERED** M.D.'s—Two part time staff positions available in leading near Loop Hair Replacement Research Institute. Individual modern medical office. Light work load, routine exams, blood pressure, etc. Call 346-9122.

**MARION**—One Internist, board eligible or certified. Permanent license any U.S. state required. Salary open to $38,000 depending on qualifications and experience. Special bonus pay of about $6,000 available. 40 hour work week, 30 days vacation, 15 days paid sick leave, 9 paid holidays, low cost life and health insurance, excellent retirement plan. Moving expenses paid. EEO. Contact Frank J. Salvati, M.D., Chief of Staff, VA Hospital, Marion, IN 46952. Phone (317) 674-3321 Collect.

**OPPORTUNITIES FOR PHYSICIANS IN INDIANA**—There are several excellent openings among the Indiana State Hospitals at various locations throughout the state for psychiatrists and physicians of other specialties, at most experience levels. A newly-revised salary schedule offers a very competitive income plus a generous package of fringe benefits. An adjunct practice is possible beyond the regular working hours and on-call responsibilities. Please reply with a copy of the c.v. to: Farabee & Associates, Inc., P.O. 8ox 472, Murray, KY 42071 or call (collect) (502) 753-9772. Farabee is retained by the Indiana Department of Mental Health.

**PHYSICIAN WANTED** for directorship of small inner city clinic which is part of comprehensive community development program. Exciting opportunity to engage in creative enterprise in primary care with enthusiastic support and participation by community residents. Please contact Mr. Steve Allen or Mr. George Walters at 722-3452.

**WANTED**—M.D. to serve as Assistant Medical Director and Assistant Director of Medical Education, 300 bed hospital. Box 908 c/o IMJ, 55 E. Monroe, Suite 3510, Chicago, IL 60603.

**FULL TIME FACULTY POSITIONS** available in the Department of Family Practice, Wright State University School of Medicine. 8oth experienced practitioners and recent residency graduates encouraged to apply. 8oard certification or board eligibility a prerequisite. Areas of activity include undergraduate teaching, residency teaching, curricular planning, continuing education for practicing physicians and multiple research opportunities. Limited practice opportunity also available if desired. Precise duties of faculty members tailored to individual interest and abilities. Interested physicians are directed to reply with curriculum vitae to John C. Gillen, M.D., Acting Chairman, Department of Family Practice, Wright State University School of Medicine, 601 Miami 8lvd., West, Dayton, Ohio 45408. Equal opportunity/affirmative action employer.

**PERFECT OPPORTUNITY** to relocate in Los Angeles, California without losing one day's income. Active Family Practice to give to qualified General Practitioner. Monthly net $6,500. Lease my fully equipped, custom built 1800 sq. ft. medical building. Will introduce. Clearence Gazin, M.D., 6711 Melrose Avenue, Los Angeles, Calif. 90038. 213-936-7259.

**EMERGENCY PHYSICIAN, McHENRY:** Full-time career-oriented emergency physician to begin July 1 in 17,000 visit/year emergency department of 140-bed mobile-intensive-care resource hospital and trauma center 50 miles northwest of Chicago. Small town (pop. 8,000). Ski and water sports area. Good back-up from 20-man multi-specialty clinic in adjacent building and from independent specialists in community. Salary and fringes competitive with Chicago area. Send curriculum vitae to: John L. Bowman, M.D., Director, Emergency Services, McHenry Hospital, 3516 W. Waukegan Road, McHenry, IL 60050.

**IMMEDIATE OPENING** in our office for a fourth internist. One of our group is near retirement; the other two are upper middle-age. We share common expenses, but maintain separate practices. This is a long-established office, with a heavy, stable, practice load, in a professional building attached to a progressive specialty-oriented hospital, in Rockford, Illinois. There is opportunity for teaching in the Rockford School of Medicine. If you are interested, please write or call: C. W. Gray, M.D. or Virgil C. Keeling, M.D., 2500 North Rockton Ave., Rockford, Illinois 61103. Telephone: 815-968-2468.

**MEDICAL DIRECTOR** for permanent, full-time position with a neighborhood health center at the University of Illinois Hospital and Medical School. Academic appointment, excellent salary and fringe benefits. Opportunity for innovative medical care research in systems and manpower. Student and community education programs. Work with inner city population adjacent to the Medical Center complex. ILLINOIS LICENSE REQUIRED. Available now. Salary, rank open. Contact Edward A. Lichter, M.D., Prof. & Head, Dept. Prev. Med. & Commu. Hlth., P.O. 8ox 6998, Chicago, Ill. 60680. Phone, 312-996-7630. The University of Illinois is an Affirmative Action-Equal Opportunity Employer and encourages applications from members of minority groups and women.

**EXPERIENCED EMERGENCY PHYSICIAN:** Teaching staff for new emergency medicine residency program; for a three-year graduate emergency medicine program in a 528 bed hospital which is a major teaching affiliate of the University of Illinois. The E.D. is a comprehensive facility with 30,000 visits per year, a triage system and a holding area located close to downtown Chicago. E.D. experience and residency in emergency medicine or other major specialty preferred. For further information contact: J. M. Gennrich, M.D., Director, Emergency Services, Mercy Hospital and Medical Center, Stevenson Expressway at King Drive, Chicago, Illinois 60616. 312/567-2200.

**PEDIATRICIAN,** full-time position with neighborhood health center at the University of Illinois Hospital and Medical School. Academic appointment, excellent salary and fringe benefits. Responsible for child health program at the center. Patients from community adjacent to the Medical Center complex. ILLINOIS LICENSE REQUIRED. Available September 1, 1977. Salary, rank open. Contact Edward A. Lichter, M.D., Prof. & Head, Dept. Prev. Med. & Commu. Hlth, P.O. Box 6998, Chicago, IL 60680. Phone, 312-996-7630. The University of Illinois is an Affirmative Action-Equal Opportunity Employer and encourages applications from members of minority groups and women.

**PHYSICIAN WANTED** for new primary care medical group on sunny Southern California coast. Calif. license. Adjacent hospital. Quality care. Exc. opportunity. Salary open. Box 909, c/o IMJ, 55 E. Monroe, Suite 3510, Chicago 60603.

## FOR SALE, LEASE OR RENT

**MEDICAL CENTER FOR RENT,** Complete and ready to open. 4300 sq. ft. at 2301 E. 95th Street, Chicago. Lge. waiting rm., 18 exam. rms., X-ray rm., central a/c & heat. Call Gary Solomon, 334-5400.

**EQUIPMENT** for five examining rooms and more. Must sell now. Five examining tables, stools, lamps, sani-cans, blood cuffs, pillows, glass medical jars. Also available ClayAdams centrifuge, American Optical one fifty microscope, typing stands, reception room furniture and dictaphone unused with thought tank. Prices as low as $100.00 for some examining tables. For information call office manager between 10:00 to 6:00 at 878-5151. Weekends call 878-5414.

**NORTH SHORE MEDICAL CLINIC,** 5011—5019 N. Sheridan Road, Chicago, Illinois. Completely remodeled—2,800 square feet, nine examination rooms, two private doctor's consultation rooms, one office with examination room reception area, laboratory, x-ray and pharmacy area. Sublet at ($1,900.00) per month including utilities until January 29, 1980.
Options available.
Call Martin Margolis at 499-1400.

**MEDICAL OFFICE SUITE FOR RENT,** Lincoln-Belmont 8ldg. 1200 to 1400 sq. ft. available January 1, 1978 in full service, elevator, professional building. Very active long established practice, leaving neighborhood. Call Gary Solomon, 334-5400.

**TO SUBLET—PART TIME—WATER TOWER PLACE:** Ophthalomolgist's office, beautifully furnished and equipped—1500 square feet divided into four examining rooms, consultation room, waiting room, secretarial office and mydriatic room. Phone DE 2-4884.

**PRACTICE FOR SALE:** Large one person general practice, in operation 36 years. Broad spectrum of patients, no O8 or pediatrics presently. Office facilities could be developed for group, spacious living accommodations adjoining the office or next door with family oriented recreational facilities (pool, tennis court, enclosed basketball court). Contact: Dr. Kielsmeier's Office, 317 Raymond St., Elgin, Ill. 60120. 312-741-4689.

## SITUATIONS WANTED

**PHYSICAL THERAPIST,** 36, highly motivated. Illinois licensed, interested in partnership with hospital or Orthopedic physicians. Ten (10) years excellent experience, heavily geared toward Orthopedics. Knowledge of fracture bracing and skeletal traction. Proven clinical and business record. Interested in a permanent situation. References and Resume upon request. 8ox 907 c/o IMJ, 55 E. Monroe, Suite 3510, Chicago, 60603.

**BOARD ELIGIBLE GENERAL INTERNIST**—Experienced in private practice and ER work—ACEP member—Willing to practice general Medicine and/or ER work full/part time—Licensed in Illinois and Ohio State—Consider any location—Please reply 8ox 906 c/o Illinois Medical Journal, 55 E. Monroe, Suite 3510, Chicago, 60603.

**CONSIDERING STAFF ADDITIONS?** Medical Assistants available throughout the state. Robert Morris College has a Medical Assisting Program accredited by the Council on Medical Education of the American Medical Association in collaboration with the American Association of Medical Assistants. Our Medical Assistants are proficient in administrative, clinical, and laboratory areas. Graduates are prescreened prior to application. No fee charged to Employer or Applicant. Call: Toll Free 800-252-9151 or (217) 357-2121; Robert Morris College Placement Center, College Avenue, Carthage, IL 62321.

**PHYSICIAN'S ASSISTANT,** 8A, MA, 31, graduate of accredited program, 8oard eligible, work experience in group practice in major medical center. Relocating. Desires position in Chicago or Northern Illinois. Contact M. J. Van Hook, 1925 Keeney Street, Evanston, Illinois 60202.

## MISCELLANEOUS

**MINI SHOPPING CENTER** . . . New enough to be reasonably trouble free . . . Old enough to have established tenants . . . 100% leased . . . 26 miles west/southwest of the Loop . . . $106,000 annual net income . . . Priced at $1,000,000 . . . Possible 65 or 70 percent mortgage . . . Invest now! Harrald E. Hayford, 1121 W. Ogden, Naperville, IL 60540. (312) 420-2777.

**PARTNER(S)** for harness horse breeding farm. Solid investment. For details call Rudy at Windmeadow Farm. (312) 682-0121 or (312) 279-8720.

## GUARANTY FUND CERTIFICATE

**GUARANTY FUND CERTIFICATE** with IL. State Medical Inter-Insurance Exchange for sale; purchased for $3,060.00. Contact: Kiran Majmundar, M.D., Travis Clinic Association, P.O. 8ox 870, Jacksonville, TX 75766, (214) 586-2505, ext. 338.

**GUARANTY FUND CERTIFICATE** issued by the Illinois State Medical Inter-Insurance Exchange for sale. Coverage $100,000/$300,000. Class 5, Specialty: Otorhinolaryngology. Original purchase price $6,840.00. Interested: Contact Olawale O. Idewu, M.D. 9204 South Commercial Avenue, Chicago Illinois 60617; Tel. (312) 734-4243.

**GUARANTY FUND CERTIFICATE,** Number 5742, Illinois State Medical Inter-Insurance Exchange, purchased at $4,792.00 for sale. This is for Territory II, Class 4 for $100,000-$300,000 coverage for General Surgery. For information please call 217-342-4128.

**GUARANTY FUND CERTIFICATE,** ISMIE, No. 589. Cost $724—Dermatology. Contact Mrs. Irving M. Cobin, 3000 Heritage Dr., Joliet, Ill. 60435.

**FOR SALE:** Guaranty Fund Certificate #5448, Territory II, Original Class 3, GP and Surgery. Original Cost $2,476.00. Call: Dr. William E. Mundl, 217-762-2108 or 217-762-2284.

**RETIRED PHYSICIAN** wishes to sell Guaranty Fund Certificate with the Illinois State Medical Inter-Insurance Exchange. Cost was $724. Will take $500. Contact: Perry Allerton, 370 Summit St., Elgin, IL 60120.

**CERTIFICATE TO SELL:** Leaving Illinois. Class V ISMS Inter-Insurance Exchange. Contact 312-799-8896.

**EMERGENCY PHYSICIAN** is selling his guaranty fund certificate (Illinois State Medical Inter-Insurance Exchange). In paid principal amount of certificate was $3,060. 8est offer, contact: 312-393-3823.

**ILLINOIS STATE MEDICAL INTER-INSURANCE EXCHANGE GUARANTY FUND CERTIFICATE.** For sale due to retirement. Principal amount $724. Asking price $500. Contact Paul R. Linden, M.D., 719-16th Street, Moline or 309-764-6705.

*IMJ and ISMS are not acting as brokers or agents; this is provided as a membership service.*




# *Viewbox*

*(Continued from page 19)*

**DIAGNOSIS:** The opaque filled structure to the left of the lumbar spine represents a contrast filled gallbladder (Figure 1) in a huge abdominal hernia. (Figures 2, 3, & 4) It appears very large because it is magnified by anterior pull from the huge ventral hernia which contains small bowel, most of the large bowel and a portion of the stomach in the hernia sac. The gallbladder size was not unusual at the time of surgery. The patient had a successful repair of the hernia.



**Figure 2**



**Figure 3**



**Figure 4**


LEASE NOW

PORSCHE 911

The ultimate sports machine. We have the largest inventory in the midwest.



AUDI 5000

The sensible luxury car. All types of leases available, long or short term.



NOW RESERVING SPRING LEASE DATES FOR PORSCHE 928's!

Doctors have special transportation needs and we have been filling them with incomparable automobiles for years. Leasing your next car makes good economic sense and we'd like to show you why.

O'HARE
INTERNATIONAL AUTOS
THE MIDWEST'S LARGEST PORSCHE AUDI DEALER
CALL VINCE PISHA (312) 297-2880



# Yours Truly™ by Jobst — it's only natural.

Finally, a truly natural external breast prosthesis is available to your patients. No need to follow the trauma of a radical mastectomy and associated psychological overlay with an ugly, even grotesque breast prosthesis of unnatural polyvinyl chloride.

Now, with the help of your nurse, Reach to Recovery volunteers, and others, you can suggest to your postmastectomy patients an external breast form that is seamless and natural. The Yours Truly™ breast form is new. Worn right against the skin it requires no special bra to stay in place. It moves with the vitality and flow of a natural breast. The silicone gel inside has a specific gravity of .98, only .04 more dense than human breast tissue and the response in vivo is nearly identical. There are thirteen sizes from which to choose, each with the contour and suppleness of the female breast size it replaces.



**Contact your local Jobst Service Center for complete details.**

**JOBST CHICAGO SERVICE CENTER**

**Chicago, Illinois 60602**
Suite 2101, Pittsfield Bldg.
55 E. Washington Street
312/346-0446

# report

Illinois Society
American Association of Medical Assistants

# *Illinois Society Shines at National Meeting*



**ILLINOIS SOCIETY DELEGATES: (L-R) Mrs. Cissy Moran, CMA, Will-Grundy Chapter immediate past president; Mrs. Phyllis Harwood, CMA, A-C, Kankakee County Chapter president; Mrs. Leslie Lee, Illinois Society president-elect; and Mrs. Vivian Kraft, CMA, A-C, Illinois Society president.**



**Mrs. Norma Domanic, L.P.N. from New Lenox, Illinois, who was elected to a two year term as trustee to the AAMA.**



**Mrs. Judith A. Miller, CMA, A-C, Triton College Medical Assistant Instructor, discusses "Comparison Codes of Ethics for the Allied Health Professions."**



**Mrs. Sarafina Bonadonna, North Shore Chapter, presents a paper entitled "Ultrasonography in Obstetrical and Gynecological Practice."**

Awards, recognition and successful elections were shared by Illinois members during the 21st annual convention of the American Association of Medical Assistants in San Francisco. Educational forums of interests were offered to the registrants on administrative, clinical and legal topics.

Great emphasis was placed on "Confident Leadership through Effective Communication" in a talk by Georgette McGregor, Ph.D., from the University of California in San Diego. Karen Zupko and Diane Palmer, both from the AMA Dept. of Practice Management, headed several seminars concentrating on personnel policies, training new medical assistants, collection methods, procedures to reduce routine, nonproductive telephone calls and effective appointment scheduling.

In the clinical realm, Rev. Dr. Mwalimu Imara of Boston, Massachusetts, discussed "Life and Transitions." Doctor Imara emphasized that death is no longer a closet topic, and particularly credited the many informative books written by Dr. Elizabeth Kubler-Ross.

Legal concerns were brought to light by David Rubsamen, M.D., J.D., of the U.S.C. School of Medicine in his presentation on the current status of malpractice litigation.

### Upgrading Membership

Mrs. Luella Mitchell, chairman of the AAMA Committee on Public Relations, conducted a most informative and educational publicity workshop that highlighted effective member-



**Mrs. A. Jean Walsh, Editor of the Chicago Bulletin (center) receives first place award in chapter publications competition. Also shown (L-R) Mrs. Winnie Schwartz, president-elect AAMA; Mrs. Mary Dunham, editor, Illini Cardinal; Mrs. Joan Michaels, CMA-A, AAMA president; Mrs. Vivian Kraft, CMA, A-C, Illinois Society president and Mrs. Mary Francis Burton, Illinois Society membership secretary.**

ship communication. It was apparent that the Spoon River Valley Chapter had achieved that goal when Mrs. Vivian Kraft, CMA, A-C, Illinois Society president, accepted a "Certificate of Recognition" on their behalf for 100% membership stabilization.

Illinois Society was also pleased to acknowledge three special honors. Doctor John L. Wright of Bloomington was selected to serve as chairman of the AAMA Physician's Advisory Board. In addition, two Illinois Society members received Distinguished Service Awards for meritorious service. Mrs. June B. Hall, CMA-A, 1975-76 Speaker of the House of Delegates and Mrs. Luella Mitchell, retiring AAMA trustee, were so honored at the national meeting.

## SPECIAL NOTE

On Sunday, February 5, 1978, an AAMA Travel Course will be held at the DeKalb Holiday Inn. Interested parties may send the $8.00 registration fee ($10.00 for non-members) to Mrs. Nancy Kruger, travel course chairman, c/o Harold R. Keegan, M.D., 401 N. Wall St., Kankakee, 60901. A detailed summary of seminar topics may be found on page 258 of the October IMJ.


**Professionals are talking about . . .**




**CLOVER LEAF TOWERS OFFICE PLAZA**

**Ideally located & suited for professionals.**

10 MINUTES TO I-90 • 30 MINUTES TO CHICAGO

**NEW 3 STORY • ALL ELECTRIC • WITH ELEVATOR**

- Heating & Air-Conditioning Included
- Carpeting — Your Color Choice
- More Than Ample Parking
- Fine Restaurant Located in Building
- Ideal For Medical, Dental Offices
- Entire Floor 10,000 Sq. Ft. — Will Divide
- Tinted Glass — FM Music
- Public & Private Restrooms
- 2 Year Lease — No Increase
- Solid Oak Doors — Vinyl Base
- Individually Controlled Thermostat
- Immediate Occupancy — Brokers Invited

**CLOVER-LEAF REALTY**

**201 E. Army Trail (1½ Miles West of Rte. 53)**
**Bloomingdale, Ill.**
**PHONE 893-1000**




Edited By JOHN M. BEAL, M.D.

*Surgical Grand Rounds are held weekly on Tuesday at 5:00 p.m. in the Offield Auditorium of the Passavant Pavilion of Northwestern Memorial Hospital. Patient presentations from Northwestern Memorial Hospital and the Veterans Administration Lakeside Hospital form the basis of the discussions. This case report was part of the Surgical Grand Rounds of June 7, 1977.*

## *Case Report:*

# Closed Mitral Commissurotomy

**Dr. William Parker:** A 24-year-old woman was admitted to Northwestern Memorial Hospital in the second trimester of her first pregnancy. She gave a three-month history of progressive dyspnea on exertion, which was associated with coughing and small amounts of blood streaked sputum. The patient also complained of orthopnea. She denied fever, chills, or chest pain. Prior history of shortness of breath, pulmonary disease or heart disease, including rheumatic fever, was not present. Her past medical history review of symptoms and family history were noncontributory.

On physical examination, she was a young, healthy-looking woman without evident acute disease. Blood pressure was 110/70, heart rate 120, and respirations 36/minute. Lung examination revealed inspiratory rales in both bases. Heart examination revealed a PMI which was 8 cm lateral to the midclavicular line on the left. S-1 and S-2 were within normal limits and there was diastolic rumble murmur heard best at the apex. A systolic murmur was not detected. Abdominal examination was normal. Cyanosis and edema were absent.

Laboratory exam found blood count and automated survey blood chemistries within normal limits. Arterial blood gases were obtained: $PO_2$ 59, $PCO_2$ 23 and pH 7.45 (room air). Admission electrocardiogram showed sinus tachycardia with right ventricular hypertrophy. Chest X-rays demonstrated a marked increase in pulmonary vasculature. The admission diagnosis was pulmonary edema secondary to mitral stenosis.

Three weeks of medical therapy with diruetics, Digoxin® and bed rest brought minimal benefit. Her respiratory difficulty persisted and she required continuous nasal oxygen. She was dyspneic walking to the bathroom down the hall. An echocardiogram and a cardiac catheterization both evidenced characteristics of tight mitral stenosis. The cardiac catheterization showed a

gradient of 35 cm of mercury between the left atrium and left ventricle. Closed mitral commissurotomy was performed. She responded well and was able to walk out of the hospital breathing comfortably.

**Dr. Richard Mintzer:** The first film, taken in the Emergency Room, showed that the heart was enlarged. There was an increase in the pulmonary vascularity bilaterally with increase in the vascularity to the upper lobes in relationship to the lower lobes. There was bilateral pleural effusion.

After approximately 10 days of medical management the heart size was unchanged. There had been some resolution of the bilateral pleural effusion but the pulmonary vasculature remained engorged. There was no evidence of left atrial enlargement, which one sometimes sees with mitral stenosis (it is more often seen with mitral insufficiency than with mitral stenosis). With mitral insufficiency, an elevation of the left main stem bronchus, a double denisty along the right heart border and straightening of the left heart border may be seen. We do see some physiological changes with pregnancy, including a relative increase in the pulmonary vascularity, but the physiological changes of pregnancy never include gross pulmonary edema or interstitial changes that we see here.

**Dr. Lawrence Michaelis:** This case is interesting from two viewpoints: the management of mitral stenosis in pregnancy and a historical review of closed mitral commissurotomy. The latter is presently a seldom-performed operation, but is a very acceptable surgical procedure in selected circumstances. Before discussing these two considerations, I will review briefly the pathophysiology of mitral stenosis.

## Mitral Stenosis

The mitral valve is named after a miter because it is shaped like a bishop's hat. It is the only bicuspid cardiac valve and its anterior leaflet accounts for about two-thirds the area of the mitral orifice. The leaflets are attached to the two papillary muscles of the left ventricle by about 100 chordae tendinae which are important in the pathology of rheumatic valvulitis.

In mitral stenosis the valve leaflets, as well as the chordae, become thickened and fused with eventual fibrosis and finally calcification. The resulting stenotic obstruction is in fact a funnel-like projection extending into the left ventricular cavity. The three-dimensional nature of the valve is easily appreciated when mitral stenosis is present. A stenotic mitral valve can be anything from thin, fibrous strands which co-opt the leaflets and prevent full opening to a solid piece of calcific material with only a pinpoint orifice. Regardless of the valve's appearance, the major pathophysiologic change in mitral stenosis is obstruction to blood flow from the left atrium to the left ventricle. The results are decreased cardiac output and increased pulmonary venous pressure. This eventually leads to atrial thickening and distension, atrial dysrhythmias, pulmonary hypertension, right ventricular failure, and in some cases, tricuspid regurgitation.

Another problem of mitral stenosis is the development of thrombus in either the left atrium (often the atrial appendage) or the valvular apparatus itself. Thrombus in this location is probably initiated by platelet aggregates developing on the damaged leaflets or subvalvular structures. These thrombi can further increase the obstruction at the mitral orifice and act as a source of emboli to all parts of the body.

The normal cardiovascular response to pregnancy is increased cardiac output and blood volume, most markedly during the second trimester. This is probably due to arterio-venous shunts across the placenta which decrease peripheral vascular resistance. In mitral stenosis, an increased blood volume and a low peripheral resistance are both detrimental because with a fixed mitral orifice, the flow across the mitral valve (cardiac output) can't increase. During the second trimester, as the total blood volume increases without the resultant increase in cardiac output, the pressure in the left atrium and pulmonary venous circuit rises and pulmonary edema persists or increases.

Today's patient had been hospitalized for four weeks with complete bed rest and intensive medical management. Despite this, she had continued to deteriorate to a Class IV condition and we were concerned about both fetal and maternal survival. She tolerated closed mitral commissurotomy very well and was discharged from the hospital nine days later without the need for anticoagulants. Six weeks later the patient had an uncomplicated vaginal delivery of a healthy, normal child. She remains in Functional Class I condition.

## Closed Mitral Commissurotomy: A History

Those of you who had your surgical training before 1965 are aware of the frequency with

which closed mitral commissurotomy was performed between 1950 and 1965. The development of the closed commissurotomy technique is one of the most interesting chapters in the history of surgery. In spite of the fact that a well-known English surgeon successfully performed the operative procedure in 1925, no serious attempt was made to repeat or refine the procedure until 1946.

In the early 1900's, theoretical discussions on the feasibility of mitral commissurotomy were published in the British medical literature but no one seriously considered it in the clinical setting. Concomitantly, a number of surgical investigators in this country, mainly at Johns Hopkins Hospital, were attempting to treat mitral stenosis by resecting segments of the mitral valve in experimental animals, but the resulting mitral insufficiency precluded survival. In 1922, Allen and Graham developed an instrument called a cardioscope through which they could visualize and excise segments of the mitral leaflets. After a suitable laboratory experience they decided to attempt resecting part of the valve in mitral stenosis clinically, but their medical colleagues referred no patients. Finally, a patient with end-stage mitral stenosis was referred by a country doctor but she died during the third stage of the procedure.

In 1923 at the Peter Bent Brigham Hospital in Boston, Cutler, a surgeon, and Levine, a cardiologist, reported an operation on an eleven-year-old girl with severe mitral stenosis. Through the left ventricle, Cutler passed a curved knife and blindly incised part of what seemed to be the mitral orifice. The patient recovered from the operation and lived for about four and a half years, but her condition did not improve.

In 1925, Henry Souttar of London performed a digital mitral commissurotomy using a blind approach via the left atrial appendage. The patient improved dramatically and Souttar reported the technical considerations of the procedure and the physiologic consequences of the operation. In 1929, Cutler and Dr. Claude Beck reported on their experience with mitral commissurotomy and summarized the ten published attempts at surgical relief of the disease. Only two of the ten patients (Cutler's and Souttar's) had survived the operation.

Souttar did not persist in his operation of digital commissurotomy for mitral stenosis because no more patients were referred to him. Sir James Mackenzie, the leading British cardiologist of the era, had great influence over other cardiologists. It was his belief that the principal pathology in mitral stenosis was in the myocardium and that the stenotic mitral orifice was of secondary importance. He was vehemently opposed to any surgical procedures for relief of the disease and his opposition prevented Souttar from continuing his work.

Dr. Samuel Levine in Boston did not agree with Sir James's opinion of the pathology of the disease. Still, American surgeons were hesitant to proceed with the operation because a suitable laboratory model had not been developed. They felt that a blind technique, i.e., digital commissurotomy through the atrial appendage, was not an appropriate surgical procedure.

## First Laboratory Model

During the early 1930's, a laboratory model of mitral stenosis in the dog was finally developed. It involved cauterizing the valve leaflets with a diathermy and then injecting cultures of *Streptococcus viridans* intravenously. Animals that survived developed changes in the valve which were quite similar to those seen in human mitral stenosis. Interestingly enough, in spite of an appropriate animal model of the disease, surgeons did not pursue attempts at operative repair. Certainly, World War II was partially responsible for this situation.

In 1945 and again in 1946, Dr. Charles Bailey of Philadelphia made two attempts at mitral commissurotomy, but both patients died. Finally, in June of 1948, Bailey operated successfully on a young woman with severe mitral stenosis and a week later brought her to Chicago for a meeting of the American College of Chest Physicians. She had made a full recovery and provided dramatic evidence of the procedure's success. Several days later, Dwight Harken of Boston performed another successful commissurotomy. Bailey used blind finger dilatation through the atrial appendage, while Harken opened the valve with a valvulotome. In England Lord Russell Brock was also performing the procedure, and by 1950 the operation became widely accepted in this country and in Europe.

## Surgical Techniques

The various surgical techniques for mitral commissurotomy include finger fracture alone, dilatation with a mechanical dilator passed

through the auricular appendage or the apex of the ventricle, incising the leaflets with a knife attached to the finger, and progressive dilatation of the stenotic valve with large metal thimbles attached to the tip of the finger.

The problem with closed mitral commissurotomy was that all patients did not do well. Occasionally, mitral regurgitation developed or became worse following commissurotomy and patients would sometimes die because of it. Another problem was thrombus in the left atrial appendage which could embolize at the time of operation, in spite of numerous techniques which were devised to extract clot from the left atrium. Following perfection of cardiopulmonary bypass techniques, many surgeons began to feel that a more accurate mitral commissurotomy could be done with cardiopulmonary bypass and direct visualization of the valve. This led to a controversy that still exists in some cardiac surgical circles, that is, the advantages of closed versus open mitral commissurotomy. Advocates of the closed procedure cite that there is no need for anticoagulation and cardiopulmonary bypass. They stress the accuracy of assessing mitral regurgitation with a beating heart. Some surgeons have also expressed the opinion that by performing commissurotomy with the heart beating and ejecting a more accurate commissurotomy is possible. They note the normal physiologic stresses distributed along the commissure of the mitral leaflets by contraction of the papillary muscles are an important aid. Advocates of the open procedure stress low mortality rates, direct vision to adequately incise the leaflets and open subvalvular obstruction and ability to extract clot from the left atrium and/or to replace the valve if necessary.

In the patient presented today we felt that a closed mitral commissurotomy, at her stage of pregnancy, would offer the greatest chance of survival to both mother and child. There would be no need for cardiopulmonary bypass, anticoagulation and the medications used during open cardiac procedures. Harken reported 394 closed mitral commissurotomies performed during pregnancy with a 1.6% maternal mortality. The fetal mortality rate in several series of closed mitral commissurotomy is 5.6%, which is excellent when compared to a 10.5% rate of fetal mortality in all women with heart disease.

In 1978, the appropriate candidate for closed mitral commissurotomy is not controversial. The patient should have pure mitral stenosis, e.g., neither mitral regurgitation nor coexisting cardiac lesions. There should be no valve calcification, history of thromboembolic episodes or heart surgery, and most surgeons who still perform the operation are reluctant to do so on patients over the age of 50. In selected patients, however, closed mitral commissurotomy is still an acceptable surgical procedure, and in certain instances, such as today's patient, it may be preferable to an open procedure.

**Dr. Arthur DeBoer:** Closed mitral commissurotomy as an operation has been replaced in most medical centers by the open technique. However, I feel that there are certain situations where a closed mitral commissurotomy is the operation of choice. The patient that has been discussed today is a specific example. The criteria that make this patient an ideal candidate for a closed mitral commissurotomy are that she is a young person with pure mitral stenosis in the final trimester of pregnancy. A closed mitral commissurotomy with pump standby is an operation that would carry a very low risk to either the patient or fetus and would offer the patient a good prospectus.

The experience of both open and closed procedures on pregnant women proved that the closed technique certainly carries a lower risk to the unborn child than cardiopulmonary bypass. Those of us who have had considerable experience with closed mitral commissurotomies have used it in the past during all three phases of pregnancy as well as immediately pre- and postdelivery. In the days of closed mitral commissurotomy before cardiopulmonary bypass was available, patients with severe mitral stenosis would frequently present in pulmonary edema and the operation was done as an emergency.

I would agree completely with Doctor Michaelis that given the circumstances of this particular patient, the operation of choice with lowest risk to both patient and fetus, would be a closed mitral commissurotomy.

### Disadvantages

There are disadvantages to the closed mitral commissurotomy. Should the patient have a large atrial thrombus at operation, perhaps the closed procedure would be abandoned. At that time the patient would be attached to cardiopulmonary bypass for a thrombectomy and an open commissurotomy. The long term results of closed mitral commissurotomies have been quite well established.

When mitral commissurotomies were done as the only choice of operation, long term follow-ups suggest that approximately 40% of the patients would require a second surgical procedure on their mitral valves. Many of these patients restenose within a relatively short period of time. It is not too unusual for a patient to require valve replacement within five years after a closed mitral commissurotomy, especially if the valve was quite fibrous and the leaflets markedly thickened. In this instance, even though an adequate orifice was obtained, the resistance of the valve opening would be sufficient to obstruct dramatic patient improvement.

Unquestionably, under modern circumstances and modalities, patients with mitral stenosis should be considered for an open valvotomy. However in some cases, such as the one under discussion today, it is my impression that a closed mitral commissurotomy would be the operation of choice, providing the operator has had a goodly amount of experience with the closed procedure.

**Dr. John Beal:** Thank you very much. I must say that I think Doctor DeBoer's comments are particularly pertinent. ◄


**Physicians,**

consider a practice in South Carolina

* low malpractice insurance rates, * the opportunity to join a group or partner or establish a new practice in a rural or urban area, * continuing medical education through a system of Area Health Education Centers, as well as two medical schools, * lower taxes, * lower cost of living, * access to both mountains and beaches, and * a mild climate

For information about specific practice opportunities in South Carolina, contact:

rural health delivery project

Post Office Box 11188
Columbia, South Carolina 29211
(803) 779-7264

**IMMEDIATE OCCUPANCY**

**park west medical plaza**

An Original Concept

*A one story medical and dental building with private entrances for each suite and ample, adjacent parking. A landscaped environment emphasizing your identity and ease of access for patients.*

SUPERB LOCATION

- *Near downtown Highland Park.*
- *3 minutes from Highland Park Hospital.*
- *One block from Skokie Highway*

OUTSTANDING ENVIRONMENT

- *A totally efficient and relaxed atmosphere.*
- *The outstanding medical building in the Chicago area.*

UNIQUE FEATURES

- *Individual thermostatic controls in all suites.*
- *Private Toilets*

COMPLETE DESIGN FLEXIBILITY

- *Architect designed and built to suit you.*
- *Easy installation of any facilities within suites.*

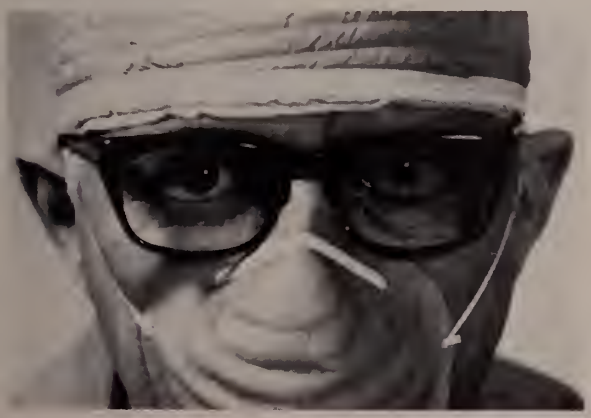
For Leasing Information Contact:

Milico Development Co. 5500 W. Touhy Avenue Skokie, Illinois 60076 (312) 674-7033

# A Source of Wound Contamination Eliminated

By Hugh A. Johnson, M.D./Rockford

Any surgeon who sometimes tackles an unusual or difficult case will eventually find himself faced with a choice between equally unsatisfactory alternatives: a dilemma. Regardless of the temperature of the operating room, the physiologic response to such a situation can be diaphoresis, some situations causing more, some less. And now we surgeons are wrapped in seemingly air-tight paper. The situation is compounded in spring and fall for those of us in the less temperate zones where we are at the mercy of thermostats unable to cope with the vagaries of our weather. To call unwanted attention to this problem an alert circulating nurse sometimes dramatically mops the surgeon's brow, occasionally sweeping a few droplets of sweat from deep-seated frontal sudoriferous glands into the open wound. I've found a means for easily preventing this awkward situation.



**Cap in contact with eyebrows to prevent perspiration from forming beads.**



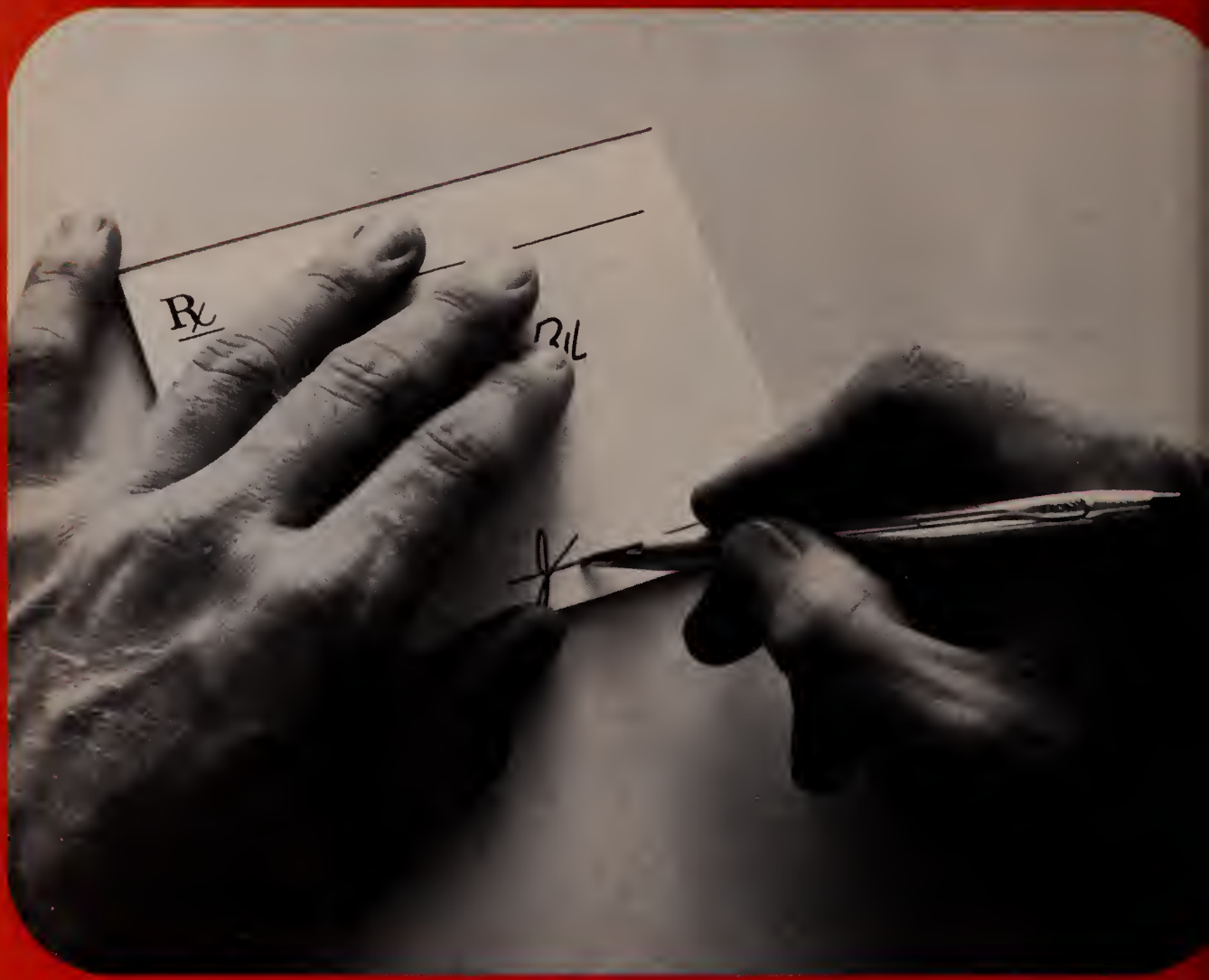
**Loupe in place over cap. This prevents irritation under the plastic rim. Every surgeon should wear some magnification device during surgery. If you do not believe that it is indicated, look at your next careful suture job, done without magnification, then with the loupe and see how much better a job you could have done. It's the difference between looking at a "no parking" sign on your side of the street, or the other side of the street.**

Eyebrows were engineered to carry sweat away from the orbits. If the surgeon's cap is worn well down on the forehead in contact with the eyebrows, or almost, perspiration will not be allowed to collect into droplets which may fall free, thus eliminating a possible source of wound contamination. A cap worn thus has an added advantage. It prevents chafing from whatever optical device the surgeon might (and should) be wearing. ◄



HUGH A. JOHNSON, M.D., is in the private practice of plastic and reconstructive surgery in the Rockford Memorial Medical Building at the Rockford Memorial Hospital. He also maintains an office at Northwoods Hospital, Phelps, Wisconsin. Dr. Johnson is a consultant to the Sumner Koch Burn Unit at Cook County Hospital, Chicago, and the St. Anthony Burn Unit, Rockford.

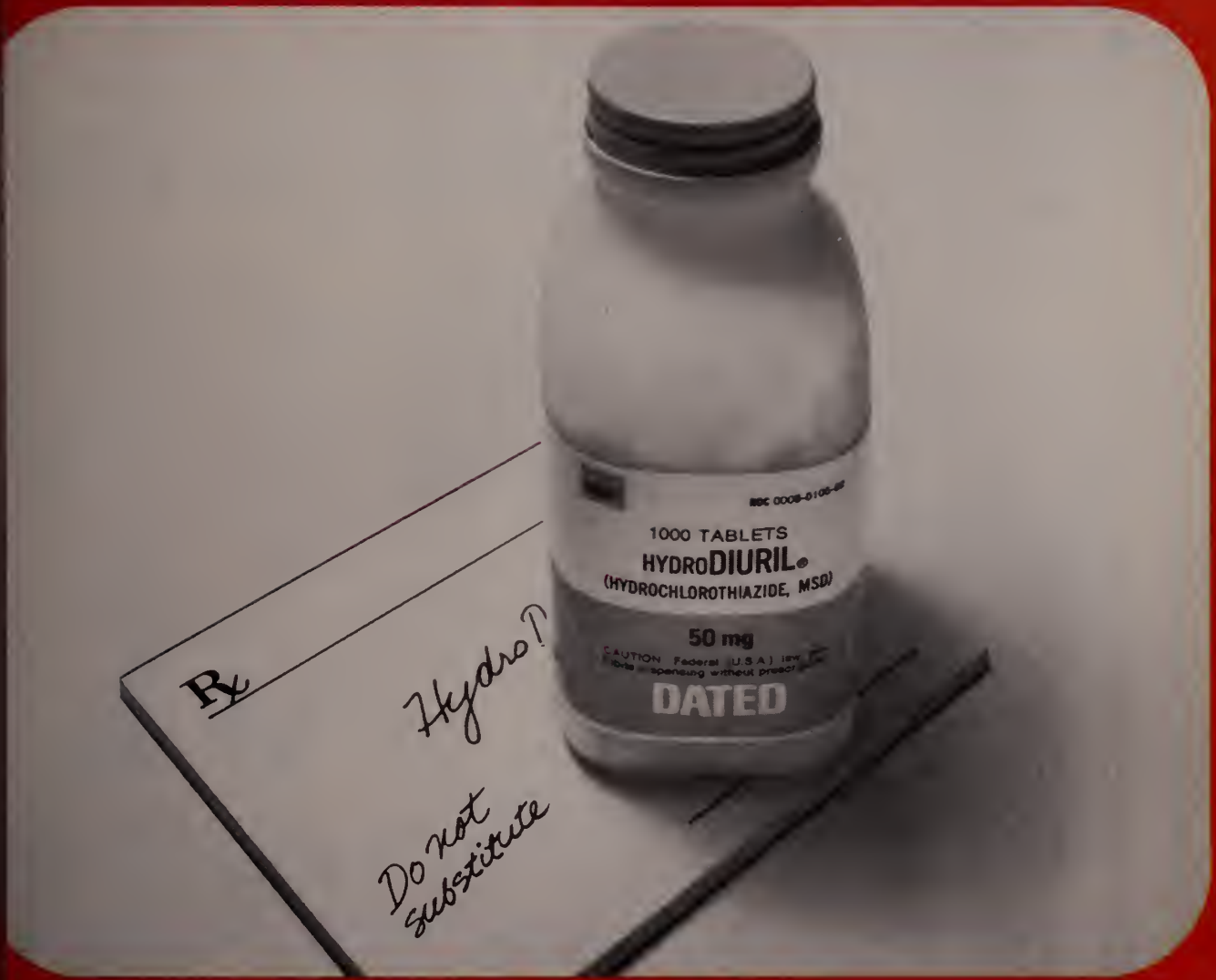
# There is no substitute




# yours...

**Contraindications:** Anuria; hypersensitivity to this or other sulfonamide-derived drugs.
**Warnings:** Use with caution in severe renal disease. In patients with renal disease, thiazides may precipitate azotemia. Cumulative effects may develop in patients with impaired renal function. Use with caution in patients with impaired hepatic function or progressive liver disease, since minor alterations of fluid and electrolyte balance may precipitate hepatic coma. May add to or potentiate action of other antihypertensive drugs; potentiation occurs with ganglionic or peripheral adrenergic blocking drugs. Sensitivity reactions may occur in patients with or without a history of allergy or bronchial asthma. Possibility of exacerbation or activation of systemic lupus erythematosus has been reported. Lithium generally should not be given with diuretics because they reduce its renal clearance and add a high risk of lithium toxicity. Read circulars for lithium preparations before use of such concomitant therapy. *Use in Pregnancy:* Thiazides cross placental barrier and appear in cord blood; in pregnancy, weigh anticipated benefit against possible hazards to fetus, including fetal or neonatal jaundice, thrombocytopenia, and possibly other adverse reactions that have occurred in adults. *Nursing Mothers:* Thiazides appear in breast milk; if use of drug is deemed essential, patient should stop nursing.
**Precautions:** Perform periodic determination of serum electrolytes to detect possible electrolyte imbalance. Observe all patients for clinical signs of fluid or electrolyte imbalance, namely, hyponatremia, hypochloremic alkalosis, and hypokalemia. Serum and urine electrolyte determinations are particularly important when patient is vomiting excessively or receiving parenteral fluids. Medication such as digitalis may also influence serum electrolytes. Warning signs, irrespective of cause, are dryness of mouth, thirst, weakness, lethargy, drowsiness, restlessness, muscle pains or cramps, muscular fatigue, hypotension, oliguria, tachycardia, and gastrointestinal disturbances such as nausea and vomiting. Hypokalemia may develop, especially with brisk diuresis in severe cirrhosis, with concomitant corticosteroid or ACTH therapy, with inadequate oral electrolyte intake. Hypokalemia can sensitize or exaggerate response of heart to toxic effects of digitalis (e.g., increased ventricular irritability). Hypokalemia may be avoided or treated by use of potassium supplements, such as foods with a high potassium content. Any chloride deficit is generally mild and usually does not require specific treatment except under extraordinary circumstances (as in liver disease or renal disease). Dilutional hyponatremia may occur in edematous patients in hot weather; appropriate therapy is water restriction, rather than administration of salt except in rare instances when the hyponatremia is life threatening. In actual salt depletion, appropriate replacement is the therapy of choice.
Hyperuricemia may occur or frank gout may be precipitated in certain patients. Insulin requirements in diabetic patients may be increased, decreased, or unchanged; latent diabetes mellitus may become manifest. Thiazides may increase responsiveness to tubocurarine. Antihypertensive effects of the drug may be enhanced in post-sympathectomy patients. May decrease arterial responsiveness to norepinephrine; this diminution is not sufficient to preclude effectiveness of the pressor agent for therapeutic use. If progressive renal im-

# for experience—




# or ours.

rment becomes evident, consider withholding or discontinuing retic therapy. Thiazides may decrease serum PBI levels without hs of thyroid disturbance. Calcium excretion is decreased by azides. Pathologic changes in the parathyroid gland with hypercemia and hypophosphatemia have been observed in a few patients prolonged therapy; thiazides should be discontinued before testing parathyroid function.

**Adverse Reactions:** *Gastrointestinal System*—Anorexia; gastric irtion; nausea; vomiting; cramping; diarrhea; constipation; jaundice rahepatic cholestatic jaundice); pancreatitis; sialadenitis.

*ntral Nervous System*—Dizziness; vertigo; paresthesias; headache; thopsia.

*matologic*—Leukopenia; agranulocytosis; thrombocytopenia; astic anemia.

*rdiovascular*—Orthostatic hypotension (may be aggravated by ohol, barbiturates, or narcotics).

*ersensitivity*—Purpura; photosensitivity; rash; urticaria; necrotizing itis (vasculitis) (cutaneous vasculitis); fever; respiratory distress uding pneumonitis; anaphylactic reactions.

*her*—Hyperglycemia; glycosuria; hyperuricemia; muscle spasm; akness; restlessness; transient blurred vision.

henever adverse reactions are moderate or severe, thiazide dosage uld be reduced or therapy withdrawn.

**te:** When used with other antihypertensive drugs, careful observans for changes in blood pressure must be made, especially during al therapy. Dosage of other antihypertensive agents must be reduced by at least 50 percent as soon as this drug is added to the regimen. As blood pressure falls under the potentiating effect of this agent, further reduction in dosage, or even discontinuation, of other antihypertensive drugs may be necessary.

**How Supplied:** Tablets containing 25 mg hydrochlorothiazide each in bottles of 100 and 1000 and single-unit packages of 100; Tablets containing 50 mg hydrochlorothiazide each in bottles of 100, 1000, and 5000 and single-unit packages of 100; Tablets containing 100 mg hydrochlorothiazide each in bottles of 100.

*For more detailed information, consult your MSD representative or see full prescribing information. Merck Sharp & Dohme, Division of Merck & Co., Inc., West Point, Pa. 19486*

J6HD04(528)

MSD
MERCK SHARP & DOHME

In hypertension

TABLETS: 25 mg, 50 mg, and 100 mg

**HydroDIURIL®**

(HYDROCHLOROTHIAZIDE|MSD)

# COLBY PROCLAIMS WOMAN SUFFRAGE

Signs Certificate of Ratification at His Home Without Women Witnesses.

MILITANTS VEXED AT PRIVACY.

Wanted Movies of Ceremony, But Both Factions Are

WASHINGTON, Aug. 26, 1920—




# Social Security Bill Is Signed, Gives Pensions to Aged, Job

## Roosevelt Approves Message Intended to Benefit 30,0 Persons When States Adopt Cooperating Laws—He the Measure 'Cornerstone' of His Economic Progr

# SENATE APPROVES 18-YEAR OLD VOTE IN ALL ELECTIONS

Amendment to Constitution is Sent to House, Where Passage is Expected

WASHINGTON, March 10, 1971—The Senate approved today 94 to 0 and sen[t]

WASHINGTON, Aug. The Social Security Bill, a broad program of unem insurance and old age and counted upon to be 20,000,000 persons, beca day when it was signed dent Roosevelt in the pr those chiefly responsible ting it through Co[n]

Mr. Roosevelt cal[led] "the cornerstone [of] which is being [built] m[o]s[t] s[i]mpl[e]

# TRUMAN CLOSES ITED NATIONS CONFEREN WITH PLEA TO TRANSLATE CHARTER INTO DEEDS

## NEW WORLD HOPE

President Hails 'Great Instrument of Peace,' Insists It Be Used

HISTORIC LANDMARK

Meeting Gives Standing Ovation as Executive Pictures Peace Gain

"If we fail to use it," he declared to the solemn final meeting of the delegates, 'we shall betray all of those who have died in order that we might meet here in freedom and safety to create it.'

"If we seek to use it selfishly—for the advantage of any one nation or any small group of nations—we shall be equally guilty of that betrayal."

Fervent Interpolation

The President, speaking in the auditorium of the War Memorial Opera House, built in memory of sons of the Golden Gate city who gave their lives in the first World War, in which he himself served, seemed to give unconscious expression to the solemn feeling of the occasion when, at the outset of his speech, he interpolated the words, half a hope, half a prayer:

"Oh, what a great day this can be in history!"

[Just before the plenary session

# IGN

# the Dra Ends N[ow]

WASHINGTON, Jan. 27, 1973—"With the signing of the peace agreement in Paris today, and after receiving a report from the



# PATIENT PACKAGE INSERTS: A CONCEPT WHOSE TIME HAS COME?

*The consumer's right to know is an irreversible and desirable trend of the Seventies. It extends, and properly, to a patient's right to know more about his or her prescription medications. One way, gaining favor, is through patient package inserts. Wisely-prepared and properly distributed when medically indicated, they could markedly improve patient knowledge and drug therapy—laudable goals by anyone's standards.*

*The PMA endorses these goals and will work with government, the health professions and consumers to achieve them.*

## The Advantages

The concept holds promise of benefits: better patient understanding of the product prescribed, better adherence to the treatment plan, and more awareness of possible side reactions.

Every doctor has had patients who fail to finish antibiotic regimens because they feel better. Some patients assume that if one tranquilizer or analgesic is good, two may be twice as good. Still others fail to report dizziness while on antihypertensive therapy —and so on.

Problems like these might arise less often if the patient received written information in addition to verbal instructions. Some studies suggest that patients are more receptive to such materials, and they more often understand the verbal instructions and follow them, when inserts are used.

## The Disadvantages

There are also some potential problems. Obviously, the inserts must be clearly phrased, without extraneous or complex detail. How much information is enough? How can it be kept current? Should all patients receive the same information? Should inserts be included with all drugs? Should only potential problems be listed or are patients better off with a "fair balance" presentation that describes usefulness as well as drawbacks?

These and similar questions require answers, since model inserts have yet to be properly developed and tested. Despite the need for these studies, the FDA is proceeding prematurely with inserts on selected products. We think the Congress is the only place where the matter can be given the proper legal status and direction, particularly since it represents a conceptual change in the legal, medical and social framework of the nation's prescription drug information system.

## The Solution

The PMA believes that carefully-devised pilot studies of various kinds of inserts are needed. They should be developed and implemented with full participation by doctors, pharmacists, consumers, communications experts and the drug industry. Such studies will provide reliable pathways to follow, so that inserts will be useful aids to medical practice.

And particularly we think that you should be closely involved in this debate and in these studies and decisions. Otherwise, people with less experience and qualifications may control the purposes, content and use of a tool with considerable promise for improved patient care. It could make a difference in your practice tomorrow, and more importantly, in the health of your patients.

PMA
THE PHARMACEUTICAL MANUFACTURERS ASSOCIATION
1155 FIFTEENTH ST, N W, WASHINGTON, D C 20005

NONPARTISAN

# IMPAC

**ILLINOIS MEDICAL POLITICAL ACTION COMMITTEE**
55 East Monroe Street
Chicago, Illinois 60603
312/782-1963

1978 is a very important year for Illinoisians interested in good government. Everyone knows two important days this year. March 21, 1978 is Primary Election day and November 7, 1978 is the General Election. However, I want to bring to your attention some other very important days this year. Between Election Day and now are 310 days just as important as March 21 and November 7.

These days are important because they give you time to campaign for the candidate of your choice. This is the opportunity for you to contribute your time and money. Get involved on behalf of your candidate -- Serve on his or her campaign committee, walk your precinct, talk to your patients and VOTE.

Remember the RX for good government is your involvement. That involvement should start with membership in IMPAC. Start off this important New Year right -- Join IMPAC today.

Pam Taylor

Pam Taylor
Chairman

---

**IMPAC/AMPAC Membership**
(check one)

- ☐ Sustaining .....$99
- ☐ Family .....$45
- ☐ Regular .....$25
- ☐ Auxiliary .....$20

Return to:
IMPAC
55 E. Monroe Street
Suite 3510
Chicago, Illinois 60630

**NAME** _____ **PHONE** _____

**ADDRESS** _____ **CITY** _____ **ZIP** _____

Contributions are not limited to the suggested amount. Neither the Illinois State Medical Society nor the AMA will favor or disadvantage anyone based upon the amounts of or failure to make pac contributions. Copies of IMPAC & AMPAC reports are filed with the Federal Election Commission, Washington, D.C. Contributions are subject to the limitations of FEC regulations, Sections 110.1, 110.2 & 110.5. (Federal regulations require this notice.) IMPAC reports are also filed with the State Board of Elections, and are or will be available for purchase from the State Board of Elections, 1020 S. Spring St., Springfield, Illinois, 62704

# A Difference in Theophylline Therapy

## micro-pulverized BRONKODYL® Capsules

brand of theophylline, USP anhydrous




- Blood levels as fast as an elixir
- With minimal gastric irritation*

*Please see complete prescribing information, a summary of which follows.

**CRIPTION:**
n green and white hard gelatin capsule contains theophylline USP anhyıs, 200 mg., in a micro-pulverized form. Each brown and white hard gelatin sule contains 100 mg. The elixir contains 80 mg. theophylline per 15 ml. 20% alcohol elixir (approximately 20 calories, 0.9 gm carbohydrate per spoontul).

**ION:** Theophylline is a methylxanthine which relaxes the smooth muscue ot the bronchioles through its inhibition of the conversion ot cyclic nosine monophosphate to adenosine monophosphate by phosphodiester- It also has diuretic, cardiotonic, and CNS stimulant effects.

**ICATIONS:** Bronkodyl is indicated for symptomatic relaxation of bronchiolar sm in the chronic obstructive bronchopulmonary diseases; e.g., bronchial ma, chronic bronchitis and pulmonary emphysema.

**NTRAINDICATIONS:** Bronkodyl is contraindicated in persons known to had serious idiosyncratic responses to theophylline, its salts, or the other hylxanthines, theobromine, or caffeine and may be contraindicated in peptic r.

**RNINGS:** All methylxanthines should be used with caution in children and in rs who are currently taking bronchodilator products, especially in rectal ige form, which may contain theophylline or related drugs.

**GE IN PREGNANCY:** Although theophylline has been used tor many s. with no evidence ot adverse fetal effect or teratogenicity, its safety in nancy has not been established. Therefore use ot Bronkodyl during lactaor in women of childbearing potential requires that possible benefits of the be weighed against possible hazards to fetus or child.

**CAUTIONS:** Bronkodyl should be used with caution in patients with cardiac rculatory disease.

**ADVERSE REACTIONS:** Gastrointestinal: Epigastric distress, nausea, vomiting. Cardiovascular: palpitations. CNS: Insomnia, restlessness, irritability, convulsion.

**DOSAGE AND ADMINISTRATION:** Adults: Usual dosage of Bronkodyl is 200 mg. every 6 hours (four doses in each 24 hours). This dosage may be adjusted to reflect individual clinical response as an indication ot slow or rapid metabolism ot the drug. It adverse reactions are encountered, each dose may be reduced, or the interval between doses may be lengthened, or both. If clinical response is not satisfactory, indicating possible rapid inactivation of the drug, dosage may be gradually increased to achieve the desired response. In some instances of either too slow or too rapid metabolism, plasma levels of theophylline should be determined and dosage adjusted accordingly to achieve levels above 10 mcg/ml, but not to exceed 20 mcg/ml.

Dosage in Children: Usual dosage should be based on administration ot 10 mg per kg per 24 hours, divided in 4 doses per day, given every 6 hours. As this may not be possible with use ot the capsules, Bronkodyl elixir may be used. Theophylline saliva levels (approximately 60% of simultaneous blood levels), may facilitate dosage adjustments, especially in children, to obtain appropriate response.

**HOW SUPPLIED:**
Bronkodyl 100 mg., brown and white capsules in 100's, Code #1831.
Bronkodyl 200 mg., green and white capsules in 100's, Code #1833.
Bronkodyl Elixir, 80 mg. per 15 ml, in pints, Code #1835.

BREON LABORATORIES INC.
90 Park Avenue, New York, N.Y. 10016

## *President's Page*



# The Profession's Image

As the new year begins, we are faced with a multi-faceted assault on our profession. Elected officials, government bureaucrats, consumer activists and others seem intent on destroying the practice of medicine as we know it.

The Federal Trade Commission has initiated legal action against organized medicine charging "restraint of trade." Additional attacks will be forthcoming unless rapidly-shrinking public confidence in the medical profession is restored.

This can be achieved only if every physician strives to meet a higher ethical standard than that imposed upon the profession as a whole. We must demonstrate to the public that we are not abusing the privileges of our profession . . . and that our primary concern is our patients, not our economic well-being.

Medicine's record of distinguished service to the public has been somewhat obscured by the health care cost problem and other controversial issues. Each of us now must share the responsibility for restoring the profession's credibility while continuing its tradition of exceptional public service.

George T. Wilkins, Jr., M.D.

# Doctor's News

**RESOLUTION DEADLINE**—Proposed resolutions for the Annual Meeting of the ISMS House of Delegates must be postmarked no later than March 5, 1978. Resolutions postmarked after that date will be considered late resolutions and require special action for possible consideration at the Annual Meeting in April.

In order to be published in the IMJ Convention Handbook, resolutions must be postmarked no later than January 29, 1978. All resolutions should be addressed to the ISMS offices, 55 E. Monroe, Suite 3510, Chicago, 60603.

**GENERIC DRUG ADVISORS NAMED**—The Illinois Department of Public Health has announced seven appointees to form a Generic Drug Technical Advisory Council. They are: Dorothy Hubler, M.D., Casey; Richard H. Suhs, M.D., Springfield; August P. Lemberger, Ph.D., Chicago; James T. O'Donnell, Pharmacy D., Palatine; Donald R. Gronewald, R.Ph., Washington; Raymond J. Cicci, R.Ph., Springfield; and Vincent A. Costanzo, M.D., R.Ph., Chicago.

The Council was established as part of the Illinois Generic Drug Act to make recommendations to IDPH toward development of a formulary listing of permissible drug substitutions. Council members will serve two-year terms without pay.

**TWO ILLINOIS HOSPITALS HONORED**—The Illinois Department of Public Health recently named St. John's Hospital, Springfield, as the state's first Regional Poison Resource Center. By calling the Center's toll-free number (800-252-2022), Illinois citizens and physicians will be able to receive 24-hour information about toxic substances. Springfield residents should call the center at 753-3330. . . . Michael Reese Hospital and Medical Center, with the participation of the University of Chicago, was awarded a grant to form one of five national kidney stone centers.

**WORKSHOPS PLANNED**—The American Academy of Family Physicians plans a series of eight workshops to aid physicians in preparing for their August, 1978, examination. The 1978 exam, which is the last one for which family doctors who never completed a family practice residency may be eligible, has an application deadline of April 1, 1978. The Illinois workshop is scheduled for March 5, at the Hyatt Regency O'Hare, Chicago. Further information is available from the Education Division, American Academy of Family Physicians, 1740 West 92nd Street, Kansas City, Mo. 64114, telephone 800-821-2512.

**PRESCRIPTION TIP**—Many physicians have called the Illinois Department of R&E Pharmacy Coordinator to ask if the so-called Brompton's Mixture can be legally prescribed. This old preparation, apparently used with some success to alleviate the problems of terminally ill patients, contains morphine and cocaine dissolved in ethyl alcohol, syrup, and chloroform water. The practitioner often will change the concentration of the morphine and cocaine and substitute different syrups (with therapeutic actions) and other vehicles (in lieu of chloroform water).

One standard formula is as follows: Morphine, 0.01; Cocaine, 0.01; ethyl alcohol, 5cc; syrup, 5cc; chloroform water qs ad 20 cc. Sig. 20cc q.4h.

A physician who is properly licensed and registered with the State of Illinois and the Drug Enforcement Administration may prescribe the above preparation. A triplicate prescription must be used for this preparation.

**PHYSICIANS IN THE NEWS**—At the November ISMS Interim Meeting, Dr. Edward Cannady, Belleville, was awarded a plaque in honor of his outstanding contributions to the Illinois Council on Continuing Medical Education. Dr. Cannady (r) aided in the Council's early development and served on its Board of Directors for five years. ISMS President George T. Wilkins, Jr., M.D., (l) presented the well-deserved award to Dr. Cannady.



**Eugene L. Derlacki, M.D.,** Wayne, president of the American Hearing Research Foundation, has been installed as president of the American Academy of Ophthalmology and Otolaryngology. . . . **Meyer Kushner, M.D.,** Chicago, has been awarded the prestigious Prime Minister of Israel Medal by the B'nai B'rith Council of Greater Chicago. Dr. Kushner is a former faculty member at the UI College of Medicine and past medical staff president of Bethesda Hospital.

**Robert J. Becker, M.D.,** Joliet, recently was re-elected president of the Joint Council of Allergy and Immunology. Dr. Becker also serves as medical director for the Quad River Foundation for Medical Care and the Quad River Professional Standards Review Organization. . . . **Richard H. Kessler,** Chicago, has been named senior vice president for professional and academic affairs of Michael Reese Hospital and Medical Center. Dr. Kessler, former associate dean for academic affairs at Northwestern University Medical School, is a professor of medicine at Northwestern, and has been appointed to the faculty of the UC Pritzker School of Medicine.

**Joseph H. Skom, M.D.,** Chicago, ISMS past president, has been named to the Illinois Dangerous Drugs Commission. Dr. Skom, who serves this year as ISMS Trustee-at-Large, will take the place of **Daniel X. Freedman, M.D.,** Chicago, on the Commission.

**TRIPLICATE 'SCRIPT**—Regulations requiring use of the official state triplicate prescription form for amobarbitol, secobarbitol and pentobarbitol have lapsed. Therefore, physicians are no longer required to write these three items on the triplicate prescription form, although these drugs remain as Schedule II controlled substances.

A special ISMS committee is reviewing all controlled substances with a view to determining a recommendation of which should logically require a triplicate prescription. Suggestions or comments are welcome.

**R&E PLANS AUDITS**—The Illinois Department of Registration and Education has announced that a series of surprise audits are planned as part of a licensure review program. The inspections will concentrate on occupations which particularly affect public welfare, such as physicians, pharmacists, detectives, security agencies and real estate brokers. The impromptu inspections could lead to more thorough investigations leading to suspension, if violations are discovered.

**NEW IDPH APPOINTEE**—M. Samuel Sudman, Dr. P.H., has been named chief of the Division of Public Health Laboratories for IDPH. Dr. Sudman is the former director of laboratory services for the State of Tennessee. He will be located at the Division's main offices in Chicago.

If you're rethinking your choice of tranquilizers, here are

# four good reasons to make it

# Tranxene® CLORAZEPATE DIPOTASSIUM

C IV

430*CS

1. Tranxene has been shown equivalent to diazepam in anti-anxiety effectiveness in controlled studies with hundreds of patients.

2. Tranxene is particularly well tolerated; excessive sedation is rarely a problem.

3. Tranxene offers oral dosing options unmatched by another tranquilizer: not only 2x0 (or more) divided dose forms, but also convenient single-dose tablets for once-a-day use at any convenient hour.

4. Tranxene is physically different in form and appearance from other widely used agents. Therefore patients will know or recognize it.

ABBOTT

Please see overleaf for prescribing information.



# Tranxene® (CLORAZEPATE DIPOTASSIUM) 4306CB

CAPSULES,
SINGLE DOSE TABLETS
**Brief Summary**

**ACTIONS** — Pharmacologically, clorazepate dipotassium has the characteristics of the benzodiazepines. It has depressant effects on the central nervous system. The primary metabolite, nordiazepam, quickly appears in the blood stream. The serum half-life is about 2 days. The drug is metabolized in the liver and excreted primarily in the urine. (See ANIMAL AND CLINICAL PHARMACOLOGY section.)

**INDICATIONS** — TRANXENE is indicated for the symptomatic relief of anxiety associated with anxiety neurosis, in other psychoneuroses in which anxiety symptoms are prominent features, and as an adjunct in disease states in which anxiety is manifested.

TRANXENE is indicated for the symptomatic relief of acute alcohol withdrawal.

The effectiveness of TRANXENE in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should reassess periodically the usefulness of the drug for the individual patient.

**CONTRAINDICATIONS** — TRANXENE is contraindicated in patients with a known hypersensitivity to the drug, and in those with acute narrow angle glaucoma.

**WARNINGS** — TRANXENE is not recommended for use in depressive neuroses or in psychotic reactions.

Patients on TRANXENE should be cautioned against engaging in hazardous occupations requiring mental alertness, such as operating dangerous machinery including motor vehicles.

Since TRANXENE has a central nervous system depressant effect, patients should be advised against the simultaneous use of other CNS-depressant drugs, and cautioned that the effects of alcohol may be increased.

Because of the lack of sufficient clinical experience, TRANXENE is not recommended for use in patients less than 18 years of age.

*Physical and Psychological Dependence:*

Withdrawal symptoms (similar in character to those noted with barbiturates and alcohol) have occurred following abrupt discontinuance of clorazepate. Symptoms of nervousness, insomnia, irritability, diarrhea, muscle aches and memory impairment have followed abrupt withdrawal after long-term use of high dosage.

Caution should be observed in patients who are considered to have a psychological potential for drug dependence.

Evidence of drug dependence has been observed in dogs and rabbits which was characterized by convulsive seizures when the drug was abruptly withdrawn or the dose was reduced; the syndrome in dogs could be abolished by administration of clorazepate.

*Usage in Pregnancy:*

**An increased risk of congenital malformations associated with the use of minor tranquilizers (chlordiazepoxide, diazepam, and meprobamate) during the first trimester of pregnancy has been suggested in several studies. TRANXENE, a benzodiazepine derivative, has not been studied adequately to determine whether it, too, may be associated with an increased risk of fetal abnormality. Because use of these drugs is rarely a matter of urgency, their use during this period should almost always be avoided. The possibility that a woman of childbearing potential may be pregnant at the time of institution of therapy should be considered. Patients should be advised that if they become pregnant during therapy or intend to become pregnant they should communicate with their physician about the desirability of discontinuing the drug.**

*Usage during Lactation:*

TRANXENE should not be given to nursing mothers since it has been reported that nordiazepam is excreted in human breast milk.

**PRECAUTIONS** — In those patients in which a degree of depression accompanies the anxiety, suicidal tendencies may be present and protective measures may be required. The least amount of drug that is feasible should be available to the patient.

Patients on TRANXENE for prolonged periods should have blood counts and liver function tests periodically. The usual precautions in treating patients with impaired renal or hepatic function should also be observed.

In elderly or debilitated patients, the initial dose should be small, and increments should be made gradually, in accordance with the response of the patient, to preclude ataxia or excessive sedation.

**ADVERSE REACTIONS** — The side effect most frequently reported was drowsiness. Less commonly reported (in descending order of occurrence) were: dizziness, various gastrointestinal complaints, nervousness, blurred vision, dry mouth, headache, and mental confusion. Other side effects included insomnia, transient skin rashes, fatigue, ataxia, genitourinary complaints, irritability, diplopia, depression and slurred speech.

There have been reports of abnormal liver and kidney function tests and of decrease in hematocrit.

Decrease in systolic blood pressure has been observed.

**DOSAGE AND ADMINISTRATION**

*For the symptomatic relief of anxiety:*

TRANXENE is administered orally. The capsules may be given in divided doses. The usual daily dose is 30 mg. The dose should be adjusted gradually within the range of 15 to 60 mg. daily in accordance with the response of the patient. In elderly or debilitated patients it is advisable to initiate treatment at a daily dose of 7.5 to 15 mg.

TRANXENE capsules may also be administered as a single dose daily at bedtime; the recommended initial dose is 15 mg. After the initial dose, the response of the patient may require adjustment of subsequent dosage. Lower doses may be indicated in the elderly patient. Drowsiness may occur at the initiation of treatment and with dosage increment.

TRANXENE-SD tablets (22.5 mg.) may be administered as a single dose every 24 hours. This tablet is intended as an alternate dosage form for the convenience of patients stabilized on a dose of 7.5 mg. capsules three times a day. TRANXENE-SD tablets should not be used to initiate therapy.

TRANXENE-SD HALF STRENGTH tablets (11.25 mg.) may be administered as a single dose every 24 hours.

*For the symptomatic relief of acute alcohol withdrawal:*

Recommended schedule: 1st 24 hours, 30 mg. TRANXENE initially, followed by 30 to 60 mg. in divided doses; 2nd 24 hours, 45 to 90 mg. in divided doses; 3rd 24 hours, 22.5 to 45 mg. in divided doses; 4th day, 15 to 30 mg. in divided doses. Thereafter gradually reduce to 7.5 to 15 mg. daily, and discontinue as soon as condition is stable. Maximum daily dose is 90 mg. Avoid excessive reductions in total drug on successive days.

**DRUG INTERACTIONS** — If TRANXENE is to be combined with other drugs acting on the central nervous system, careful consideration should be given to the pharmacology of the agents to be employed. Animal experience indicates that TRANXENE prolongs the sleeping time after hexobarbital or after ethyl alcohol, increases the inhibitory effects of chlorpromazine, but does not exhibit monoamine oxidase inhibition. Clinical studies have shown increased sedation with concurrent hypnotic medications. The actions of the benzodiazepines may be potentiated by barbiturates, narcotics, phenothiazines, monoamine oxidase inhibitors or other antidepressants.

If TRANXENE is used to treat anxiety associated with somatic disease states, careful attention must be paid to possible drug interaction with concomitant medication.

**MANAGEMENT OF OVERDOSAGE** — Overdosage is usually manifested by varying degrees of CNS depression ranging from slight sedation to coma. As in the management of overdosage with any drug, it should be borne in mind that multiple agents may have been taken.

There are no specific antidotes for the benzodiazepines. The treatment of overdosage should consist of the general measures employed in the management of overdosage of any CNS depressant. Gastric evacuation either by the induction of emesis, lavage, or both, should be performed immediately. General supportive care, including frequent monitoring of the vital signs and close observation of the patient, is indicated. Hypotension, though rarely reported, may occur with large doses. In such cases the use of agents such as Levophed® (levarterenol) or Aramine® (metaraminol) should be considered.

While reports indicate that individuals have survived overdoses of TRANXENE (clorazepate dipotassium) as high as 450 to 675 mg., these doses are not necessarily an accurate indication of the amount of drug absorbed since the time interval between ingestion and the institution of treatment was not always known. Sedation in varying degrees was the most common physiological manifestation of TRANXENE overdosage. Deep coma when it occurred was usually associated with the ingestion of other drugs in addition to TRANXENE.

**CLINICAL PHARMACOLOGY** — Studies in healthy men have shown that TRANXENE has depressant effects on the central nervous system. Prolonged administration of single daily doses as high as 90 mg. was without toxic effects. Abrupt cessation of high doses was followed in some patients by dizziness, insomnia, irritability, diarrhea, muscle aches, or memory impairment.

*Absorption – Excretion:*

After oral administration of TRANXENE, there is essentially no circulating parent drug. Nordiazepam, its primary metabolite, quickly appears in the blood stream. In 2 volunteers given 15 mg. (50 μC) $^{14}$C-TRANXENE, about 80% was recovered in the urine and feces within 10 days. Excretion was primarily in the urine with about 1% excreted per day on day 10.

**HOW SUPPLIED** — TRANXENE (clorazepate dipotassium) is supplied as capsules in three dosage strengths:

3.75 mg. capsules (gray with white cap) in bottles of 100 (NDC 0074-3417-13) and 500 (NDC 0074-3417-53). Also available in ABBD-PAC® unit dose packages of 100 capsules (NDC 0074-3417-11).

7.5 mg. capsules (gray with maroon cap) in bottles of 30 (NDC 0074-3418-30), 100 (NDC 0074-3418-13) and 500 (NDC 0074-3418-53). Also available in ABBD-PAC unit dose packages of 100 capsules (NDC 0074-3418-11).

15 mg. capsules (all gray) in bottles of 100 (NDC 0074-3419-13) and 500 (NDC 0074-3419-53). Also available in ABBO-PAC unit dose packages of 100 capsules (NDC 0074-3419-11).

TRANXENE-SD single dose tablets are supplied in two dosage strengths:

TRANXENE-SD 22.5 mg. tablets (tan-colored) in bottles of 100 (NDC 0074-2997-13).

TRANXENE-SD HALF STRENGTH 11.25 mg. tablets (blue-colored) in bottles of 30 (NDC 0074-2699-30) and 100 (NDC 0074-2699-13).

7113C


If you're rethinking your choice of tranquilizers, there are four good reasons to make it

Tranxene® (CLORAZEPATE DIPOTASSIUM)



# *Bilateral Knee Effusions in Sickle Cell Crisis*

A 29-year-old black male was admitted for painful sickle cell crisis and bilateral knee effusions. Two days previously he had noted mild upper respiratory symptoms followed by onset of chest wall pain which rapidly spread to include the low back and extremities. Both knees became painful and swollen. Past history revealed a diagnosis of sickle cell (SS) disease made 10 years prior to admission during an episode of painless jaundice, and followed by recurrent crises. Multiple episodes of cholecystitis had occurred and culminated in removal of his gall bladder. The last crisis occurred five months ago and was associated with right knee swelling. Joint aspiration at that time revealed unremarkable fluid. An X-ray of the knee was normal. Patient had occasional post-crisis right knee pain and swelling, exacerbated by weight bearing, which continued until the present admission.

Examination on admission revealed a temperature of 38.5°C. The cough was irritative and rales were heard in the left lower lobe. The sputum was purulent. There were multiple tender boney sites over extremities and ribs. Both knees were warm and swollen with ballotable fluid present. There was marked tenderness and limitation of motion on flexion bilaterally. Full extension was impossible. Other joints were normal to examination.

**TABLE 1**
**Bone and Joint Lesions in Sickle Cell Disease**

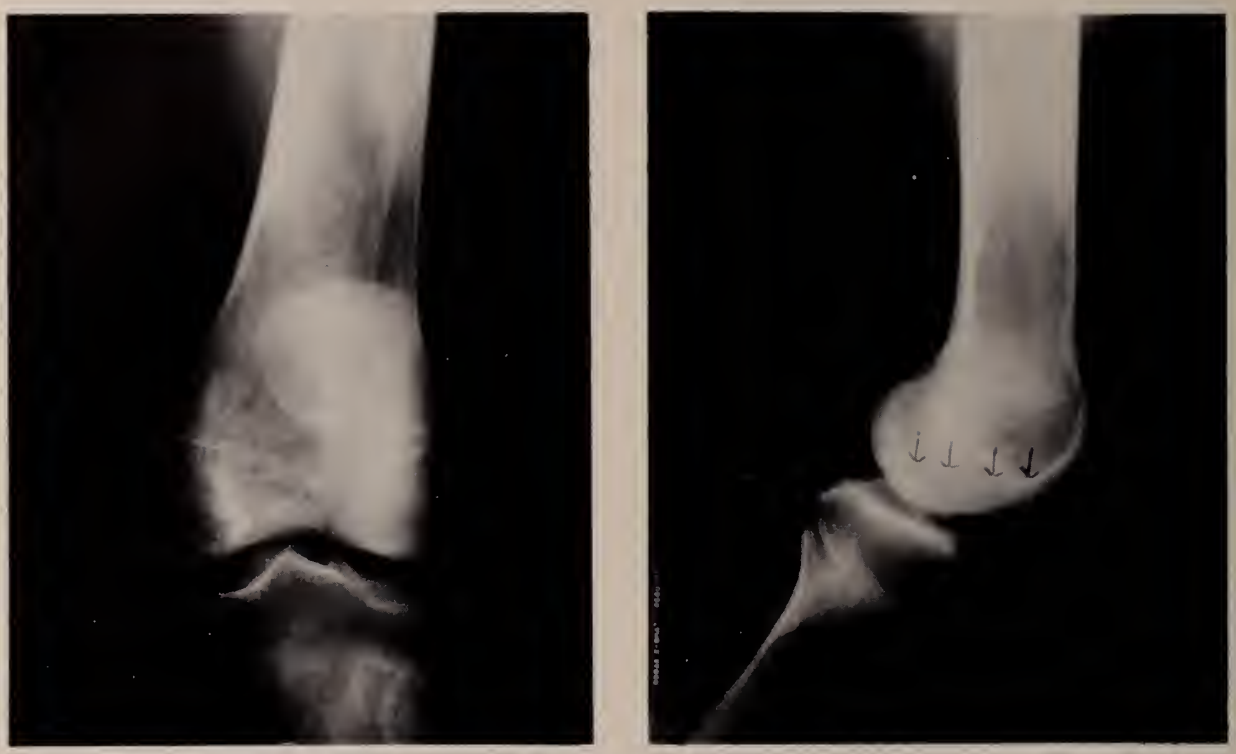
| | |
|---|---|
| Bone: | Cortical infarction |
| | Aseptic Necrosis |
| | Osteomyelitis |
| Joint: | Septic Joint |
| | Gout |
| | Synovial Infarct |
| | Aseptic Necrosis |
| | Hemochromatosis |

## Laboratory Findings

The hemoglobin was 8.7, hematocrit 24.7%. Peripheral smear revealed polychromasia, sickling, targeting and howell-jolly bodies. Reticulocytes were 14%. The white blood count was 13,000 with 76% polymorphs and 5% bands. The SMA 18 was normal excepting an LDH of 830, uric acid of 3.8 and bilirubin total 5.5/direct 1.0. Electrocardiogram, coagulation studies and urinalysis were within normal limits. Rheumatoid factor and antinuclear antibody were absent in serum. Chest X-ray revealed a left lower lobe infiltrate. Sputum cultures grew out pneumococcus. Blood and urine cultures, and urethral swab for gonococcus were negative. X-rays of the left knee were normal. X-rays of the right knee are seen in Figure 1. Joint aspiration in both knees were similar and revealed clear, amber fluid with good viscosity and mucin clot. The white cell count was 1960 with 23% polymorphs; the red cell count was 9050 with sickled cells present. There were no crystals seen. The glucose was normal. Gram stain and culture of the fluid was negative.

## Comment

Bone and joint lesions[1] are a frequent source of complaints in the adult sickle cell patient (see Table 1). Pain of crisis caused by infarction of cortical bone is the most familar to clinicians. Small sequestra of dead bone result and undergo reabsorption or sclerosis. Such infarctions, if large enough, cumulatively lead to a mottled lucent and sclerotic X-ray picture with irregular periosteal reaction. When infarcts involve subchondral bone, aseptic necrosis[2] develops. Here the dead sequestrum of bone, often large, is covered by cartilage and synovium on one side. Such a sequestrum is reabsorbed poorly, if at all, and



**A sequestrum of bone resembling osteochondritis dessicans can be seen in the medial condyle of the femur on the AP view. The lateral reveals a thin line of fracture extending across the condyle arrow.**

may lead to collapse of the involved area, freeing loose bodies into the joint space. Accelerated degenerative arthritis is a frequent sequelae. Pain exacerbated by weight bearing, limitation of motion and variable amounts of fluid may be present, but onset is often insidious and not always associated with crises. X-ray changes are late, and a normal X-ray does not rule it out. Bone scan is positive early, but is hard to distinguish from that of cortical infarct associated with crises. The heads of the femur and humerus are the most common sites involved, but other areas have been reported.

During crises it may be difficult, if not impossible, to distinguish between aseptic necrosis and cortical infarction, as well as osteomyelitis,[3] which is some 50 times more common in sickle cell patients than in normals. All may have fever, bone pain and elevated white counts. Early X-rays may be normal in all three and bone scan will be indiscriminately positive. A high index of suspicion and close post-crisis follow-up may allow differentiation.

Infarcts of synovium alone may occur during crisis and have been shown to be due to occlusion of small synovial vessels by sickled cells.[1,4] This presents clinically during crises as acute joint effusions associated with warmth, pain and limited motion in variable degrees. Rarely, it may be the only manifestation of crises. Joint fluid characteristics are variable but usually benign. X-rays show no specific changes. Such effusions are transient, abating in 2-10 days, and require no other treatment than that of the underlying crises. This benign manifestation is a diagnosis of exclusion, however, and more treatable causes of synovitis must be ruled out. Septic joints may occur, especially if infection underlies the crises, and must always be monitored. A variety of organisms may be involved. Hyperuricemia[5] occurs in 40% of SS patients and acute gouty arthritis may be present. Hyperuricemia is usually secondary to increased urate production associated with hemolysis, but

in older sickle patients a renal lesion[6] may be involved. In patients who have received multiple transfusions with past crises, the arthropathy of hemochromatosis may occur. Hemarthrosis[7] is only seen secondary to trauma.

### Conclusion

The patient was treated with antibiotics, fluids and analgesics for his pneumonia and crisis. He improved rapidly and both knee effusions resolved with bed rest alone as the crises abated. The right knee X-ray revealed aseptic necrosis at least several months old. In retrospect it was supposed that this had occurred during his previous crisis, and had been cause of knee symptoms over the ensuing five months. No bacteria or crystals could be found in either knee effusion on this admission. They resolved with the crises and were presumably transient effusions of synovial infarction.

Aseptic necrosis can be difficult to treat. Avoidance of weight bearing may allow dead bone reabsorbtion as new bone is laid down. This is seldom successful long term, however, and joint replacement is frequently required. Recently, joint replacement has been accomplished successfully in sickle cell patients.[8] Our patient was discharged on crutches, transferred to a cane as an out-patient, and will be followed on this conservative regimen. ◄

### References


1. Shumacher, H. R.: "Rheumatological Manifestations of Sickle Cell Disease and other Heredity Haemoglobinopathies," *Clinics in Rheumatic Diseases,* 1:37-52, 1975.
2. Tanaka, K. R., Clifford, A. O., Axelrod, A. R.: "Sickle Cell Anemia (Homozygous S) with Aseptic Necrosis of the Femoral Head," *Blood,* 11:998-1008, 1956.
3. Engh, C. A., Hughes, J. L., Abrams, R. C., et al.: "Osteomyelitis in the Patient with Sickle Cell Disease," *J. Bone Joint Surg.* 53A:1-15, 1971.
4. Espinoza, L. R., Spilberg, I., Osterland, C. K.: "Joint Manifestations of Sickle Cell Disease," *Medicine,* 53: 295-305, 1974.
5. Gold, M. S., Williams, J. C., Spivack, M., *et al.:* "Sickle Cell Anemia and Hyperuricemia," *JAMA* 206:1572-1573, 1968.
6. Ball, G. U. and Sorenson, L. B.: "The Pathogenesis of Hyperuricemia and Gout in Sickle Cell Anemia," *Arth. and Rheum.,* 13:846-848, 1970.
7. Hamilton, E. B. D.: "The Arthritis of Hyperparathyroidism, Hemochromatosis and Wilson's Disease," *Clinics in Rheumatic Diseases,* 1:109-123, 1975.
8. Habermann, E. T., and Grayzel, A. I.: "Bilateral Total Knee Replacement in a Patient with Sickle Cell Disease," *Clin. Orthop.,* 100:211-218, 1974.



# MEDICLINICS

POSTGRADUATE MEDICAL REFRESHER COURSE

# FORT LAUDERDALE, FLORIDA

MARCH 6 - 17, 1978

SPONSORED BY FLORIDA ACADEMY OF FAMILY PRACTICE AND
THE BROWARD MEDICAL CENTER

"This program is acceptable for 50 (Prescribed Hours) by the American Academy of Family Physicians."

**PRE-REGISTRATION — $300.00**

MEDICLINICS
832 Central Medical Building
Saint Paul. Minnesota 55104

**EXCELLENT FACULTY, FINEST HOTEL, PEAK OF WINTER SEASON**

IMJ
Illinois Medical Journal

# YOUR ADVERTISERS

*Our advertisers serve the Medical Profession and support your Journal. All advertisers are approved by your Journal Committee. It will help you and your society to mention your Journal when writing them.*

## Space Representatives

United Media Associates, Inc., 16 Bruce Park Avenue, Greenwich, Conn. 06830

## Pharmaceuticals


| | | | |
|---|---|---|---|
| 81-82 | Abbott Laboratories<br>*Tranxene* | 31-34 | Mead Johnson Laboratories<br>*Colace*<br>*Vasodilan*<br>*Quibron* |
| 77 | Breon Laboratories<br>*Bronkodyl* | 7-8 | Merck Sharp & Dohme<br>*Aldomet* |
| 16-18 | Boehringer Ingelheim<br>*Catapres* | 72-73 | Merck Sharp & Dohme<br>*Hydrodiuril* |
| 20-21 | Burroughs Wellcome Co.<br>*Cardilate* | Covers 3&4 | Roche Laboratories<br>Div. of Hoffman-LaRoche<br>*Librium* |
| Cover 2 | Burroughs Wellcome Co.<br>*Empirin Compound w/Codeine #3*<br>*Empracet w/Codeine #3* | 5 | Roche Laboratories<br>Div. of Hoffman-LaRoche<br>*Valium* |
| 23-24 | Geigy Pharmaceuticals<br>Div. of Ciba-Geigy Corp.<br>*Tofranil—P.M.* | 12-13 | Warren-Teed Laboratories<br>*Kaon Elixir and Tabs* |
| 63 | Jobst Institute<br>*Breast Prostheses* | | |
| 26 | Eli Lilly and Company<br>*Kefzol* | | |


## Insurance


| | | | |
|---|---|---|---|
| 61 | Medical Protective Co.<br>*Professional Liability Ins.* | 37 | Parker Aleshire and Co.<br>*Group Insurance* |


## Services and Continuing Education


| | | | |
|---|---|---|---|
| 60 | Classified Advertising | 62 | O'Hare International Autos<br>*Leasing Service* |
| 65 | Clover Leaf Towers<br>*Office Space* | 70 | Park West Medical Plaza<br>*Office Space* |
| 30 | Cook County Graduate School<br>*Continuing Medical Education* | 74-75 | Pharmaceutical Manufacturer's Assn.<br>*Patient Package Inserts* |
| 42 | Intrav<br>*Scandinavian Adventure* | 70 | South Carolina Medical Assn.<br>*Practice Opportunities* |
| 40 | ISMS Guide to Continuing Medical Education | 58 | University of Illinois Medical Center<br>*International Study Tour* |
| 15 | Medical World News | | |
| 85 | Mediclinics<br>*Medical Refresher Course* | | |

# 5 BENEFITS THAT MAKE LIBRIUM® LIBRIUM® (IV)
## (chlordiazepoxide HCl)
## THE ANXIETY-SPECIFIC




### . AN EXCEPTIONAL RECORD OF ANTIANXIETY PERFORMANCE
Proven effectiveness within a wide margin of safety

### . A DOCUMENTED RECORD OF FAVORABLE EXPERIENCE
More than a decade and a half of effective clinical use

### . A CONSISTENT PATTERN OF PATIENT RESPONSE
Specific, predictable antianxiety action

### . AN OUTSTANDING RECORD OF SAFETY
Seldom associated with serious side effects (the most common are dose-related and, therefore, largely avoidable)

### . USED CONCOMITANTLY WITH MANY PRIMARY MEDICATIONS
Little or no interference with many primary medications

**IBRIUM®**
**hlordiazepoxide HCl)**
**mg, 10 mg, 25 mg capsules**

**efore prescribing, please consult complete oduct information, a summary of which fol-ws:**

**dications:** Relief of anxiety and tension occurr-g alone or accompanying various disease ates

**ntraindications:** Patients with known hyper-nsitivity to the drug

**arnings:** Warn patients that mental and or ysical abilities required for tasks such as driv-g or operating machinery may be impaired, as ay be mental alertness in children, and that oncomitant use with alcohol or CNS depres-nts may have an additive effect. Though physi-al and psychological dependence have rarely een reported on recommended doses, use cau-on in administering to addiction-prone individu-s or those who might increase dosage. With-awal symptoms (including convulsions), follow-g discontinuation of the drug and similar to ose seen with barbiturates, have been re-orted.

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

**Precautions:** In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

**Adverse Reactions:** Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

***Usual Daily Dosage:*** Individualize for maximum beneficial effects. *Oral—Adults.* Mild and moderate anxiety and tension, 5 or 10 mg *t.i.d.* or *q.i.d.*; severe states, 20 or 25 mg *t.i.d.* or *q.i.d.* *Geriatric patients:* 5 mg *b.i.d.* to *q.i.d.* (See Precautions.)

**Supplied:** Librium® (chlordiazepoxide HCl) *Capsules*, 5 mg, 10 mg and 25 mg—bottles of 100 and 500; Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10. Prescription Paks of 50, available singly and in trays of 10. Libritabs® (chlordiazepoxide) *Tablets*, 5 mg, 10 mg and 25 mg—bottles of 100 and 500. With respect to clinical activity, capsules and tablets are indistinguishable.

ROCHE
Roche Products Inc
Manati, Puerto Rico 00701

# A DOCUMENTED RECORD OF FAVORABLE EXPERIENCE

The current status of Librium (chlordiazepoxide HCl) in the treatment of anxiety and conditions aggravated by anxiety has been achieved as a result of clinical experience so extensive that it demanded a computerized storage and retrieval system.

This experience, which most likely includes your own, has shown the predictability of patient response to Librium. And that its most common side effects are dose-related and, therefore, largely avoidable. In most cases, there is a highly favorable benefits-to-risk ratio and minimal interference with many primary medications.

Librium offers you a documented record of efficacy supported by clinical experience in millions of patients.




LIBRARY
FEB 9 1978
NEW YORK ACADEMY
OF MEDICINE

# THAT'S WHAT MAKES LIBRIUM® LIBRIUM®

## chlordiazepoxide HCl/Roche



## THE ANXIETY-SPECIFIC

Please see summary of product information on preceding page.

BALCONY

# Illinois Medical Journal

OFFICIAL JOURNAL OF THE
ILLINOIS STATE MEDICAL SOCIETY

Volume 153, No. 2, February 1978

NEW YORK ACADEMY OF MEDICINE ) EXCH
LIBRARY, PERIODICALS DEPT.
2 EAST 103RD STREET
NEW YORK, NEW YORK 10029

New Cost Containment Series . . . 125

ssional Liability
920's IMJ Series Revisited . . . 104

Drug Pharmacokinetics in Kidney Disease . . . 111

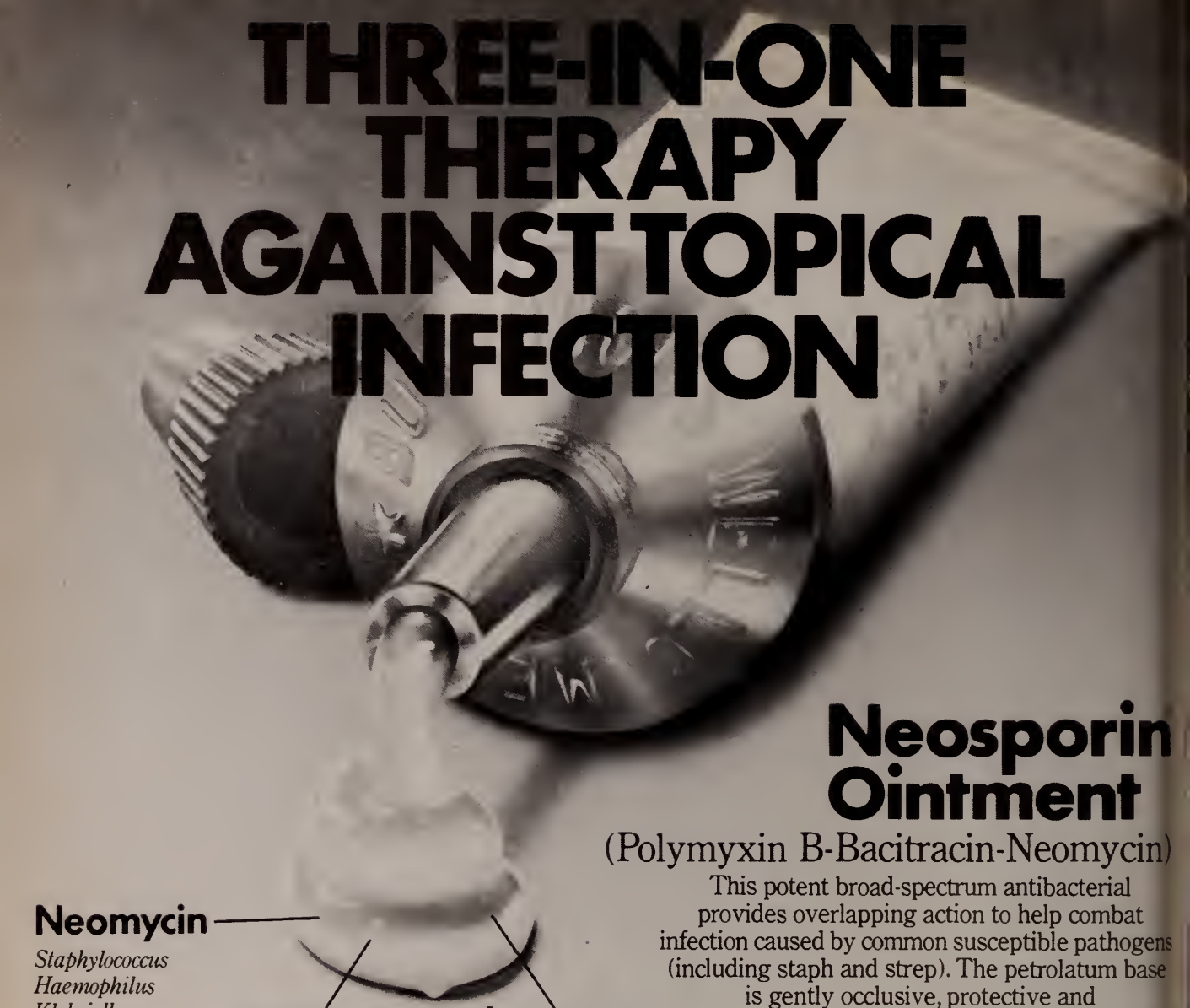
Weighing the Benefits of Environmental Decontamination . . . 121

njury to the Neck and Mediastinum: Treatment Considerations . . . 129

Detecting Asymptomatic Bacteriuria in Juvenile Diabetics . . . 118

President's Page .....158
Table of Contents ..... 87

# THREE-IN-ONE THERAPY AGAINST TOPICAL INFECTION



## Neosporin Ointment

(Polymyxin B-Bacitracin-Neomycin)

This potent broad-spectrum antibacterial provides overlapping action to help combat infection caused by common susceptible pathogens (including staph and strep). The petrolatum base is gently occlusive, protective and enhances spreading.

**Neomycin**

*Staphylococcus*
*Haemophilus*
*Klebsiella*
*Aerobacter*
*Escherichia*
*Proteus*
*Corynebacterium*
*Streptococcus*
*Pneumococcus*

**Bacitracin**

*Staphylococcus*
*Corynebacterium*
*Streptococcus*
*Pneumococcus*

**Polymyxin B**

*Pseudomonas*
*Haemophilus*
*Klebsiella*
*Aerobacter*
*Escherichia*

*In vitro* overlapping antibacterial action of Neosporin® Ointment (polymyxin B-bacitracin-neomycin).

Wellcome

**Burroughs Wellcome Co.**
Research Triangle Park
North Carolina 27709

---

## Neosporin® Ointment

(Polymyxin B-Bacitracin-Neomycin)

Each gram contains: Aerosporin® brand Polymyxin B Sulfate 5,000 units; zinc bacitracin 400 units; neomycin sulfate 5 mg (equivalent to 3.5 mg neomycin base); special white petrolatum qs; in tubes of 1 oz and 1/2 oz and 1/32 oz (approx.) foil packets.

**WARNING:** Because of the potential hazard of nephrotoxicity and ototoxicity due to neomycin, care should be exercised when using this product in treating extensive burns, trophic ulceration and other extensive conditions where absorption of neomycin is possible. In burns where more than 20 percent of the body surface is affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended.

When using neomycin-containing products to control secondary infection in the chronic dermatoses, it should be borne in mind that the skin is more liable to become sensitized to many substances, including neomycin. The manifestation of sensitization to neomycin is usually a low grade reddening with swelling, dry scaling and itching; it may be manifest simply as failure to heal. During long-term use of neomycin-containing products, periodic examination for such signs is advisable and the patient should be told to discontinue the product if they are observed. These symptoms regress quickly on withdrawing the medication. Neomycin-containing applications should be avoided for that patient thereafter.

**PRECAUTIONS:** As with other antibacterial preparations, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

**ADVERSE REACTIONS:** Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section).

Complete literature available on request from Professional Services Dept. PML.

IMJ

Illinois Medical Journal

FEBRUARY, 1978 Vol. 153, No. 2 CONTENTS

*Clinical Articles*

111 Drug Pharmacokinetics in Patients with Renal Failure
*by T. R. Franson, R.Ph., and E. T. Sorensen, M.D./Rockford*

117 Acutely Disturbed Psychotic Patients Treated with Parenteral Haloperidol
*by Randall J. Firling, M.D./Skokie*

118 The Detection of Asymptomatic Bacteriuria in Juvenile Diabetes Mellitus
*by Richard P. Nelson, M.D., Thomas J. Marr, M.D. and Howard S. Traisman, M.D./Chicago*

121 Environmental Decontamination: A Major Approach to Infection Control?
*by Larry D. Edwards, M.D./Rockford*

129 CME Conference: Penetrating Wounds of the Neck and Mediastinum
*by G. V. Paniker, M.D. and Thomas G. Baffes, M.D., Esq./Chicago*

*Professional Liability*

104 Actions for Civil Malpractice
*by Robert J. Folonie, LL.B./Chicago*

*Attacking the Cost Crisis*

125 *by J. M. Ingalls, M.D., George W. Mungerson, Richard C. Shaw, M.D., and Robert W. Seeger/Paris and Chicago*

*Seminars in Immunopathology and Oncology*

150 *Richard J. Ablin, Ph.D., Contributing Editor*
Brown Recluse Spider Bites—Some Immunologic Aspects
*by Philip C. Anderson, M.D./Columbia, Missouri*

*Surgical Grand Rounds*

154 Case Report: Gastrointestinal Hemorrhage in a Three-Year-Old Child
*John M. Beal, M.D., Contributing Editor*

*President's Page*

158 Physicians' Viewpoint on Cost Containment
*George T. Wilkins, Jr., M.D.*

*(Contents continued on overleaf)*

## *Features*


89 Clinics for Crippled Children

92 EKG of the Month

93 Editorial

99 Viewbox

100 Obituaries

109 Guest Editorial

136 Physician Recruitment Program

138 Housestaff News

143 Illinois Society, American Association of Medical Assistants

144 Pulse of the ISMS Auxiliary

146 ISMS Guide to Continuing Medical Education

148 New Pharmaceutical Specialties

157 Classified Advertising

159 Doctor's News


## *Staff*


**Managing editor** ..... **Richard A. Ott**

**Assistant editor** ..... **Mariann E. McGuire**

**Executive administrator** ..... **Roger N. White**


*(Cover by Richard A. Ott)*


### PUBLICATIONS COMMITTEE

Lawrence L. Hirsch, M.D., Chicago, *Chairman*
Kenneth A. Hurst, M.D., Naperville
Robert P. Johnson, M.D., Springfield
Alfred J. Kiessel, M.D., Decatur
Herman Wing, M.D., Chicago

---

**Contributor in Surgery:** John M. Beal, M.D., Chicago
**Contributor in Maternal Death Studies:**
Robert Hartman, M.D., Jacksonville
**Contributor in Pediatric Perplexities:** Ruth Andrea Seeler, M.D., Chicago
**Contributor in Radiology:** Leon Love, M.D., Maywood
**Contributor in Cardiology:** John R. Tobin, M.D., Maywood
**Contributor in Immunopathology:** Richard J. Ablin, Ph.D., Chicago
**Contributor in Rheumatology:** L. F. Layfer, M.D., Chicago

### ILLINOIS STATE MEDICAL SOCIETY

#### OFFICERS

George T. Wilkins, M.D., President
3165 Myrtle, Granite City 62040
David S. Fox, M.D., President-Elect
826 E. 61st St., Chicago 60637
Theodore Grevas, M.D., 1st Vice-President
2701 17th St., Rock Island 61201
William M. Lees, M.D., 2nd Vice-President
6518 North Nokomis, Lincolnwood 60646
Eugene P. Johnson, M.D., Secretary-Treasurer
P.O. Box 68, Casey 62420

#### HOUSE OF DELEGATES

Cyril C. Wiggishoff, M.D., Speaker
25 E. Washington, Suite 1805, Chicago 60602
Robert P. Johnson, M.D., Vice Speaker
108 Maple Grove, Springfield 62707

#### TRUSTEES

1st District: 1980, John Ring, M.D.
Mundelein
2nd District: 1980, Allan L. Goslin, M.D.
712 N. Bloomington, Streator 61364
3rd District: 1980, Herschel Browns, M.D.
4600 N. Ravenswood, Chicago 60640
3rd District: 1979, Alfred Clementi, M.D.
675 W. Central Rd., Arlington Heights 60005
3rd District: 1980, Audley F. Connor, Jr., M.D.
3233 King Dr., Chicago 60616
3rd District: 1978, Harold J. Lasky, M.D.
55 E. Washington, Chicago 60602
3rd District: 1979, Robert T. Fox, M.D.
2136 Robincrest, Glenview 60025
3rd District: 1978, Henrietta Herbolsheimer, M.D.
5528 S. Hyde Park Blvd., Apt. 1202, Chicago 60637
3rd District: 1978, Lawrence L. Hirsch, M.D.
2434 Grace, Chicago 60618
3rd District: 1978, Eugene T. Hoban, M.D.
6429 North Ave., Oak Park 60302
3rd District: 1980, Joseph C. Sherrick, M.D.
303 E. Superior, Chicago 60611
3rd District: 1979, Herman Wing, M.D.
155 N. Narbor Dr., Chicago 60601
4th District: 1979. Fred Z. White, M.D.
723 N. 2nd St., Chillicothe 61523
5th District: 1979, Paul F. Mahon, M.D.
326 N. 7th St., Springfield 62702
6th District: 1978, Robert R. Hartman, M.D.
1515 A. W. Walnut, Jacksonville 62650
7th District: 1979, Alfred J. Kiessel, M.D.
1 Powers Lane Pl., Decatur 62521
8th District: 1979, James Laidlaw, M.D.
104 W. Clark, Champaign 61820
9th District: 1978, Warren D. Tuttle, M.D.
203 N. Vine St., Harrisburg 62946
10th District: 1978, Julian W. Buser, M.D.
6600 W. Main, Belleville 62223
11th District: 1980, Kenneth A. Hurst, M.D.
52 Bunting Lane, Naperville 60450
12th District: 1980, P. John Seward, M.D.
2400 N. Rockton, Rockford 61101
Trustee-At-Large: Joseph Skom, M.D.
707 Fairbanks Ct., Chicago 60611
Chairman of the Board: Robert T. Fox, M.D.
2136 Robincrest, Glenview 60025



Microfilm copies of current as well as some back issues of the *Illinois Medical Journal* may be purchased from Xerox University Microfilm, 300 North Zeeb Road, Ann Arbor, Mich. 48106.

Contents of *IMJ* are listed in the *Current Contents/Clinical Practice.*

Published by the Illinois State Medical Society, 55 E. Monroe St., Chicago, Ill. 60603 (312-782-1654)



Copyright, 1978. The Illinois State Medical Society. All material subject to this copyright may be photocopied for the noncommercial purpose of scientific or educational advancement.



Subscription $8.00 per year, in advance, postage prepaid, for the United States, Cuba, Puerto Rico, Philippine Islands and Mexico. $10.00 per year for all foreign countries included in the Universal Postal Union. Canada $8.50. U.S. Single current copies available at $1.00 ($1.10 by mail), back issues $1.50.

Second class postage paid at Chicago, Ill. When moving please notify Journal office of new address including old mailing label with notification, if possible. POSTMASTER: Send notice on form No. 3579 to Illinois State Medical Society, 55 E. Monroe St., Chicago, Ill. 60603.

Pharmaceutical advertising must be approved by the ISMS Publications Committee. Other advertising accepted after review by Publications Committee or Board of Trustees. All copy or plates must reach the Journal office by the fifteenth of the month preceding publication. Rates furnished upon request.

Original articles will be considered for publication with the understanding that they are contributed only to the *Illinois Medical Journal.* The ISMS denies responsibility for opinions and statements expressed by authors or in excerpts, other than editorial or allied views or statements which reflect the authoritative action of the ISMS or of reports on official actions, policies or positions. Views expressed by authors do not necessarily represent those of the Society; any connection with official policies is coincidental.

The *Illinois Medical Journal* is published by the Illinois State Medical Society as an educational and professional informational magazine and distributed as a benefit of membership in the Illinois State Medical Society. Its intent is to keep members current in medical knowledge and is a part of a continuing medical education program. Socioeconomic matters; affecting as they do a changing pattern in the proper delivery of medical care, are considered an inherent element in medical education.

# Thirty-four Clinics for Crippled Children Listed for March

Thirty-four clinics for Illinois physically handicapped children have been scheduled for March by the University of Illinois, Division of Services for Crippled Children. The Division will count twenty-four general clinics providing diagnostic orthopedic, pediatric, speech and hearing examination, along with medical, social and nursing services. There will be nine special clinics for children with cardiac conditions and one for children with cerebral palsy. Any private physician may refer to or bring to a convenient clinic any child or children for whom he may want examination or consultative services.

March 1 Hinsdale, Hinsdale Sanitarium
March 2 Effingham, St. Anthony Memorial Hospital
March 2 Sterling, Community General Hospital
March 2 Lake County Cardiac, Victory Memorial Hospital
March 3 Division Cardiac, U. of I. at the Medical Center
March 7 Carrollton, Boyd Memorial Hospital
March 7 Park Ridge Cardiac, Lutheran General Hospital
March 8 Carmi, Carmi Township Hospital
March 8 Champaign-Urbana, McKinley Hospital
March 8 Joliet, St. Joseph's Hospital
March 8 Chicago Heights General, St. James Hospital
March 9 Springfield, St. John's Hospital
March 9 Macomb, McDonough District Hospital
March 10 Chicago Heights Cardiac, St. James Hospital
March 13 Peoria Cardiac, St. Francis Hospital
March 14 Peoria, St. Francis Hospital
March 14 East St. Louis, Christian Welfare Hospital
March 15 Centralia, St. Mary's Hospital
March 15 Rockford, St. Anthony's Hospital
March 15 Springfield Pediatric Neurology, St. John's Hospital
March 15 Evergreen Park, Little Company of Mary Hospital
March 16 Elmhurst Cardiac, Memorial Hospital of DuPage County
March 16 West Frankfort, Union Hospital
March 17 Chicago Heights Cardiac, St. James Hospital
March 17 Kankakee Cardiac, St. Mary's Hospital
March 20 Maywood, Loyola Medical Center
March 21 Rock Island, Moline Public Hospital
March 21 Decatur, Decatur Memorial Hospital
March 21 Belleville, St. Elizabeth's Hospital
March 22 Chicago Heights General, St. James Hospital
March 22 Elgin, Sherman Hospital
March 27 Peoria Cardiac, St. Francis Hospital
March 28 Peoria, St. Francis Hospital
March 28 Alton, Alton Memorial Hospital

The Division of Services for Crippled Children is the official state agency established to provide medical, surgical, corrective and other services and facilities for diagnosis, hospitalization and after-care for children with crippling conditions or who are suffering from conditions that may lead to crippling. In carrying on its program, the Division works cooperatively with local medical societies, hospitals, the Illinois Children's Hospital-School, civic, and fraternal clubs, visiting nurse associations, local social and welfare agencies, local chapters of the National Foundation and other interested groups. In all cases the work of the Division is intended to extend and supplement, not supplant activities of other agencies, either public or private, state or local, carried on in behalf of crippled children.



**Librax®**
Each capsule contains 5 mg chlordiazepoxide HCl and 2.5 mg clidinium Br.

**Please consult complete prescribing information, a summary of which follows:**

**Indications:** Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

"Possibly" effective: as adjunctive therapy in the treatment of peptic ulcer and in the treatment of the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.

Final classification of the less-than-effective indications requires further investigation.

**Contraindications:** Glaucoma; prostatic hypertrophy, benign bladder neck obstruction; hypersensitivity to chlordiazepoxide HCl and/or clidinium Br.

**Warnings:** Caution patients about possible combined effects with alcohol and other CNS depressants, and against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Physical and psychological dependence rarely reported on recommended doses, but use caution in administering Librium® (chlordiazepoxide HCl) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions) reported following discontinuation of the drug.

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy. Advise patients to discuss therapy if they intend to or do become pregnant.**

As with all anticholinergics, inhibition of lactation may occur.

**Precautions:** In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship not established.

**Adverse Reactions:** No side effects or manifestations not seen with either compound alone reported with Librax. When chlordiazepoxide HCl is used alone, drowsiness, ataxia, confusion may occur, especially in elderly and debilitated; avoidable in most cases by proper dosage adjustment, but also occasionally observed at lower dosage ranges. Syncope reported in a few instances. Also encountered: isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent, generally controlled with dosage reduction; changes in EEG patterns may appear during and after treatment, blood dyscrasias (including agranulocytosis), jaundice, hepatic dysfunction reported occasionally with chlordiazepoxide HCl, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax typical of anticholinergic agents, *i.e.*, dryness of mouth, blurring of vision, urinary hesitancy, constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.

ROCHE
Roche Products Inc.
Manati, Puerto Rico 00701




## The action of Librium®
## (chlordiazepoxide HCl)

## A significant advantage of adjunctive

# Librax®

Each capsule contains
5 mg chlordiazepoxide HCl and
2.5 mg clidinium Br.

## Antianxiety
## Antisecretory
## Antispasmodic

Librax is unique among G I medications in providing the specific antianxiety action of Librium® (chlordiazepoxide HCl) as well as the potent antisecretory and antispasmodic actions of Quarzan® (clidinium Br) for adjunctive therapy of irritable bowel syndrome* and duodenal ulcer.*

*Librax has been evaluated as possibly effective for this indication.
Please see brief summary of prescribing information on preceding page.

ROCHE

## *Illinois Attorneys Organize Political Action Committee*

The Illinois State Bar Association has formed an organization to provide financial support to candidates in state legislative races.

Illinois Lawyers' Political Action Committee (LAWPAC) was established in November of 1976 as "a voluntary, non-profit, unincorporated committee of individual lawyers and others" by the Illinois State Bar Association Assembly. An organizational meeting was held late in 1977.

LAWPAC may contribute to both primary and general election candidates, but no more than $250 will be given to a candidate in any one election campaign. LAWPAC bylaws further stipulate that Board of Trustees members, appointed by the Illinois State Bar Association president and confirmed by the assembly, may not hold any political office and that no more than four of the eight members may subscribe to the same political party.

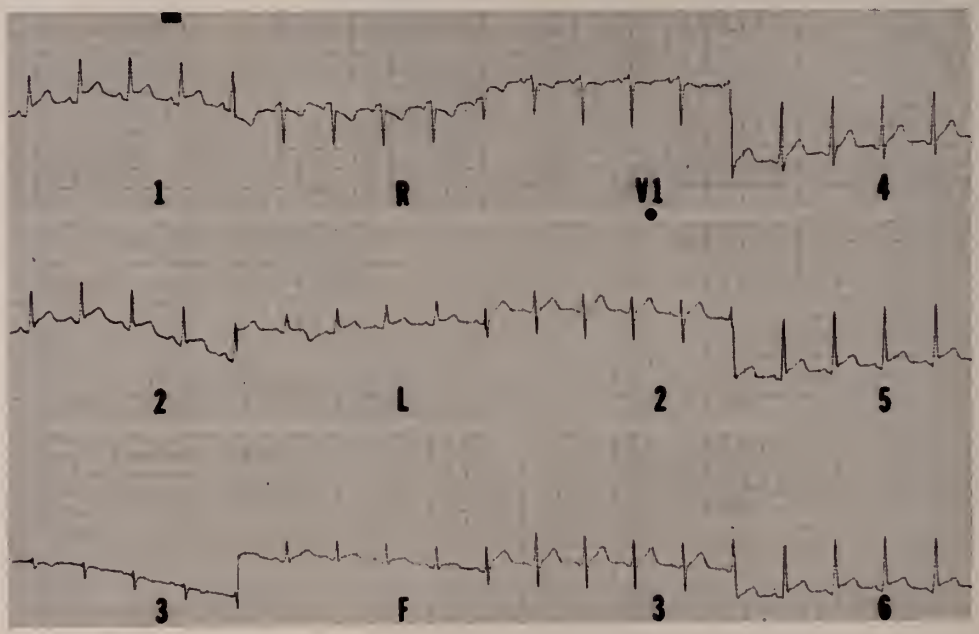
LAWPAC bylaws state seven specific purposes for the organization. These include: stimulating attorneys and others to become more active in governmental affairs; encouraging knowledge about the workings of our governmental system and the records of office holders and candidates; assisting the promotion of more effective political and civic activity; supporting the policies of the Illinois State Bar Association; and providing financial support for state candidates (in no case indicating individual endorsement). Finally, they will not advance activities which are not designed to promote professional or bar-oriented interests.

Modane®
(danthron)
LAXATIVE TABLETS
one tablet usually brings
gentle, overnight relief
WARREN-TEED
LABORATORIES, INC.
DIVISION OF ADRIA LABORATORIES INC.
COLUMBUS, OHIO 43215

# ekg of the month

John F. Moran, M.S., M.D., David L. Fishman, M.D.,
Patrick J. Scanlon, M.D., Sarah A. Johnson, M.D.,
John R. Tobin, M.S., M.D., and Rolf M. Gunnar, M.S., M.D.
Section of Cardiology, Department of Medicine,
Loyola University Stritch School of Medicine

A twenty-seven-year-old man came to the emergency service because of severe, sharp chest pains. The previous week he had had an upper respiratory infection and felt feverish and chilly but had been able to work. Then, the preceding evening, chest pains started and he was unable to sleep. The chest pains were located in the left precordium and seemed to worsen when he lay down. He obtained some relief by sitting up and leaning forward. The pain was now spreading to his left shoulder and occurring with respiration. Examination of the heart showed a pulse rate of 112/minute and a friction rub at the left sternal border. The rub contained three components. His lungs were clear and the remainder of the exam was significant only in that the patient was anxious and in much pain. The 12 lead ECG was taken.




## *Questions:*

**1. The ECG shows:**
- A. An acute anterolateral wall myocardial infarction.
- B. Voltage for left ventricular hypertrophy.
- C. ST segment elevation, a current of injury.
- D. Sinus tachycardia rate 112/minute.
- E. Atrial tachycardia.

**2. The folowing statement(s) are true:**
- A. An echocardiogram would be helpful.
- B. A chest X-ray should be ordered.
- C. The differential diagnosis of this patient's problem could include the following etiologies: myocardial infarction, uremia, infection, neoplasm, collagen disease, trauma, rheumatic disease, and idiopathic.
- D. Distended neck veins and pulses paradoxus should be watched for.
- E. All of the above.

*(Continued on page 163)*

# Editorials



## *Legal Disaster*

During and immediately following natural disasters such as tornados, forest fires and earthquakes, most people are concerned and become involved—at least vicariously—either by talking about it, sending financial aid, or considering how to prevent such severe loss in the future. But as the news reports dwindle and other events demand attention, the long term pain and suffering of disaster victims tend to be forgotten, except by those intimately involved!

This sequence of events can also be applied to a medical liability suit. All too often (almost invariably) when a claim of "malpractice" is made against a physician there is immediate press coverage and, most often, speculation as to "just how evil can that Doctor be?" There has been a significant improvement in the "malpractice crisis" due to the activity of many members of this Society, along with others; but to those who have been victimized, there is still "pain and suffering."

Physicians who have been embarrassed by false accusations and attendant unpleasant publicity are invited to submit to the *Journal,* for publication, conclusive evidence of their total legal exoneration. We shall be pleased to continue in the tradition of the American free press by printing facts in an unbiased and responsible fashion.

**L.L.H.**

# *Clinical experience & continuing confidence*

KAON® ELIXIR was introduced in **1954,** followed by KAON® TABLETS in **1963.** Decades of clinical experience indicate acceptability, effectiveness, and safety in the majority of patients; should abdominal pain occur, therapy should be discontinued. Both have been taken by patient after patient, day after day, year after year, to correct potassium deficiencies. Both have consistently demonstrated their value when diet alone is inadequate for potassium replacement.

## Kaon® Elixir
(potassium gluconate)

## Kaon® Tabs
(potassium gluconate)

BRIEF SUMMARY
**Kaon Tablets/Kaon Elixir**

**KAON® (potassium gluconate) TABLETS**

**Description:** Each sugar-coated tablet supplies 5 mEq. of elemental potassium (as potassium gluconate 1.17 Gm.). Kaon Tablets are sugar coated, not enteric coated, which favors dissolution in the stomach and absorption before reaching the small intestine where the lesions with enteric potassium chloride have occurred. The sugar coating merely adds to palatability and ease of swallowing, not to delay absorption as does the enteric coating.
**Indications:** Oral potassium therapy for the prevention and treatment of hypokalemia which may occur secondary to diuretic or corticosteroid administration. It may be used in the treatment of cardiac arrhythmias due to digitalis intoxication.
**Contraindications:** Severe renal impairment with oliguria or azotemia, untreated Addison's disease, adynamia episodica hereditaria, acute dehydration, heat cramps and hyperkalemia from any cause.
**Warning:** There have been several reports, published and unpublished, concerning nonspecific small-bowel lesions consisting of stenosis, with or without ulceration, associated with the administration of enteric-coated potassium tablets alone or when they are used with nonenteric-coated thiazides or certain other oral diuretics. These small-bowel lesions have caused obstruction, hemorrhage and perforation. Surgery was frequently required and deaths have occurred. Available information tends to implicate enteric-coated potassium salts, although lesions of this type also occur spontaneously. Therefore, coated potassium-containing formulations should be administered only when indicated and should be discontinued immediately if abdominal pain, distention, nausea, vomiting, or gastrointestinal bleeding occur. Coated potassium tablets should be used only when adequate dietary supplementation is not practical.
**Precautions:** In response to a rise in the concentration of body potassium, renal excretion of the ion is increased. With normal kidney function, it is difficult, therefore, to produce potassium intoxication by oral administration. However, potassium supplements must be administered with caution, since the amount of the deficiency or daily dosage is not accurately known. Frequent checks of the clinical status of the patient, and periodic ECG and/or serum potassium levels should be made. High serum concentra-

*Time is the test of all things*

1954
1978



ons of potassium ion may cause death through ardiac depression, arrhythmias or arrest. This rug should be used with caution in the presence f cardiac disease.

In hypokalemic states, especially in patients n a salt-free diet, hypochloremic alkalosis is a ossibility that may require chloride as well as otassium supplementation. In these circum- ances, Kaon (potassium gluconate) should be upplemented with chloride. Ammonium chlo- de is an excellent source of chloride ion (18.7 Eq. per Gram), but it should not be used in atients with hepatic cirrhosis where ammonium alts are contraindicated. Other sources for hloride are sodium chloride and Diluted ydrochloric Acid, U.S.P.

It should also be kept in mind that ammonium ycle cation exchange resin, sometimes used to eat hyperkalemia, should not be administered to patients with hepatic cirrhosis.

**Adverse Reactions:** Nausea, vomiting, diarrhea and abdominal discomfort have been reported. The symptoms and signs of potassium intoxication include paresthesias of the extremities, flaccid paralysis, listlessness, mental confusion, weakness and heaviness of the legs, fall in blood pressure, cardiac arrhythmias and heart block. Hyperkalemia may exhibit the following electrocardiographic abnormalities: disappearance of the P wave, widening and slurring of QRS complex, changes of the S-T segment, tall peaked T waves, etc.

**Overdosage:** Potassium intoxication may result from overdosage of potassium or from therapeutic dosage in conditions stated under "Contraindications." Hyperkalemia, when detected, must be treated immediately because lethal levels can be reached in a few hours.

**KAON® (potassium gluconate) ELIXIR**

**Description:** Each 15 ml. (tablespoonful) supplies 20 mEq. of elemental potassium (as potassium gluconate, 4.68 Gm.) with saccharin and aromatics. Alcohol 5%.

**Indications:** See Kaon Tablets.

**Precautions:** See Kaon Tablets.

In hypochloremic alkalosis, potassium replacement with potassium chloride (e.g., Kaochlor® 10% Liquid) may be more advantageous than with other potassium salts.

**Adverse Reactions:** See Kaon Tablets.

**Overdosage:** See Kaon Tablets.

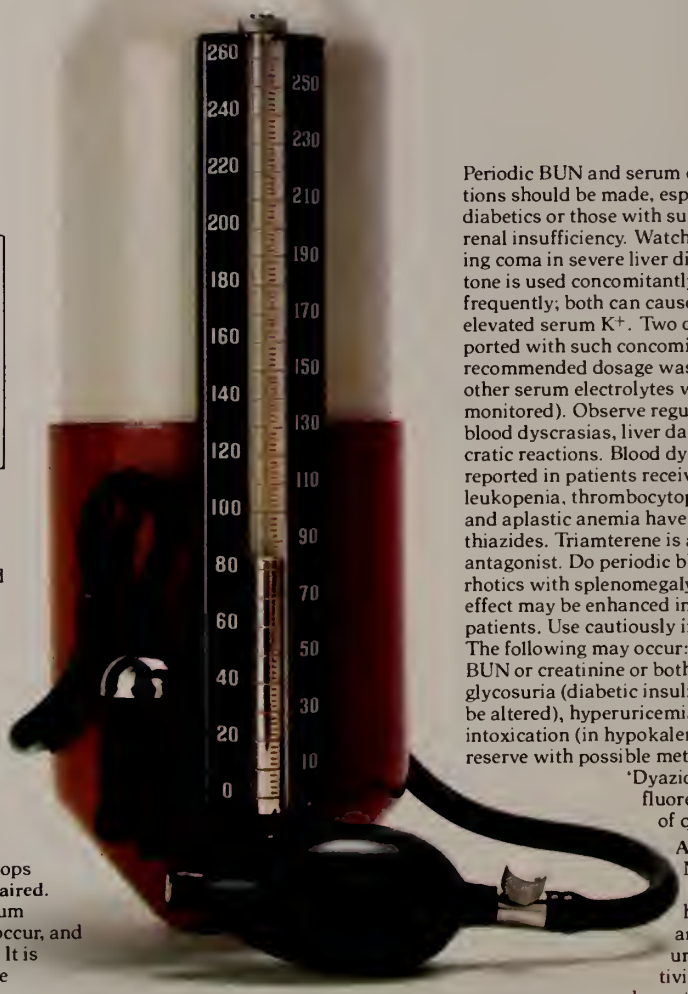
**WARREN-TEED**
LABORATORIES, INC.
DIVISION OF **ADRIA LABORATORIES INC.**
COLUMBUS, OHIO 43215

# TRIAMTERENE CONSERVES POTASSIUM WHILE HYDROCHLOROTHIAZIDE LOWERS BLOOD PRESSURE

# DYAZIDE®

Each capsule contains 50 mg. of Dyrenium® (triamterene, SK&F Co.) and 25 mg. of hydrochlorothiazide.

## MAKES SENSE




Before prescribing, see complete prescribing information in SK&F Co. literature or PDR. A brief summary follows:

* **Warning**
This drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual. If this combination represents the dosage so determined, its use may be more convenient in patient management. Treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

* **Indications:** When the combination represents the dosage determined by titration: Adjunctive therapy in edema associated with congestive heart failure, hepatic cirrhosis, the nephrotic syndrome. Corticosteroid and estrogen-induced edema, idiopathic edema; hypertension, when the potassium sparing action of triamterene is warranted. (See Box Warning.) Routine use of diuretics in healthy pregnant women is inappropriate; they are indicated in pregnancy only when edema is due to pathological causes.

**Contraindications:** Further use in anuria, progressive renal or hepatic dysfunction, hyperkalemia. Pre-existing elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs.

**Warnings:** Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired. If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in the severely ill, with urine volume less than one liter/day, the elderly and diabetics with suspected or confirmed renal insufficiency. Periodically, serum $K^+$ levels should be determined. If hyperkalemia develops, substitute a thiazide alone, restrict $K^+$ intake. Associated widened QRS complex or arrhythmia requires prompt additional therapy. Thiazides cross the placental barrier and appear in cord blood. Use in pregnancy requires weighing anticipated benefits against possible hazards, including fetal or neonatal jaundice, thrombocytopenia, other adverse reactions seen in adults. Thiazides appear and triamterene may appear in breast milk. If their use is essential, the patient should stop nursing. Adequate information on use in children is not available.

**Precautions:** Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Watch for signs of impending coma in severe liver disease. If spironolactone is used concomitantly, determine serum $K^+$ frequently; both can cause $K^+$ retention and elevated serum $K^+$. Two deaths have been reported with such concomitant therapy (in one, recommended dosage was exceeded, in the other serum electrolytes were not properly monitored). Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with thiazides. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effect may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine.

**Adverse Reactions:** Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances. Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and, rarely, allergic pneumonitis have occurred with thiazides alone.

**Supplied:** Bottles of 100 and 1000 capsules; Single Unit Packages of 100 (intended for institutional use only).

**FOR LONG-TERM CONTROL OF HYPERTENSION.* SERUM $K^+$ AND BUN SHOULD BE CHECKED PERIODICALLY. (SEE WARNINGS SECTION.)**

SK&F CO., Carolina, P.R. 00630

SK&F CO.
a SmithKline company

Blue Cross® Blue Shield®

# REPORT FOR *Illinois Physicians*

## Procedures Added To Medical Necessity Listing

In the November 1977 issue of Illinois Medical Journal, Blue Shield informed physicians that it would no longer *routinely* pay for certain named surgical and diagnostic procedures which were considered obsolete or inappropriate.

After consultation with the Illinois Psychiatric Society and the Illinois Society of Pathology the procedures listed below were considered to be inappropriate in most instances and will no longer be routinely paid by Blue Shield. There may be situations, however, when the procedures will be medically justified.

Additions to the list include the following: Transorbital frontal lobotomy; cephalin fluocculation; thymol turbidity; BSP; spinal fluid pandy and spinal fluid colloidal gold.

Blue Shield, therefore, is requesting physicians to submit with their Blue Shield Physician's Service Report, a statement indicating why a procedure on the list was medically necessary. The statement will be reviewed by our Medical staff.

If the Blue Shield claim is denied, any charge for related hospital services will also be denied by Blue Cross.

Therefore it will be to the advantage of the physician and his patient to consider the medical necessity of the above named additional procedures prior to their being performed. In the interest of high quality care at appropriate cost we seek the physician's cooperation in this mutually advantageous program.

Medical questions relating to the program may be directed to the Medical Department, Blue Cross and Blue Shield, 233 N. Michigan Avenue, Chicago, Illinois 60601. Non-medical questions may be directed to our professional Relations Department.

## Pre-Admission Testing Program Saves Hospital Care Expenses

One of the Blue Cross programs designed to conserve health care dollar expenditures is PAT—the Pre-Admission Testing Program for patients requiring surgery. One hundred and fifteen hospitals in Illinois, with the approval and cooperation of their surgical staffs offer the program to their patients.

PAT is implemented in the following manner:

After the surgical diagnosis has been established, surgery scheduled and the patient's room is reserved, those tests normally ordered by the physician prior to the operation, which in his judgement can be performed on an outpatient basis without detriment to his patient, will be paid by Blue Cross.

Results of the tests and examinations are reported to the surgeon and are made a part of the patient's record at the time of admission to the hospital. The charges become part of the inpatient bill of Blue Cross and are paid according to the benefits of the Blue Cross certificate held by the member.

Tests that are diagnostic or similar procedures not related to the condition for which inpatient surgery is required, research studies, case findings or surveys are not covered under the PAT program.

The tests must be done at the hospital and the surgeon determines the time period prior to admission in which the tests are to be performed. If surgery is postponed or cancelled, Blue Cross will still provide the benefits unless the patient decides he does not want to have surgery performed.

If your hospital offers the PAT program, we urge you and your surgical colleagues to utilize it to the maximum extent possible. If your hospital has not established a PAT program, we suggest that you discuss the program with the hospital administrator and chief of surgical staff.

A brochure describing this program is available on request from the Professional Relations Department, Blue Cross and Blue Shield, 233 North Michigan Avenue, Chicago, Illinois 60601.

# Disclosure of Physician or Supplier Payment Information

The "Government in the Sunshine Act" (Public Law 94-409) which was passed in March 1977, made legal the disclosure of certain information to the public. This information had previously been denied under the Freedom of Information Act and/or certain other statutes and regulations governing the disclosure of information.

The secretary of Health, Education and Welfare has determined that the release of certain information from Medicare records is in the public interest and would not constitute an unwarranted invasion of privacy. The information to be released includes the disclosure of physician or supplier name and address information, and the amounts of Medicare payments made to the individual physicians or suppliers and to groups of physicians or clinics.

The Medicare carriers have been instructed to extract from their files a record of all payment information from the preceding calendar year, for every physician or supplier that they serve. This will include individual physicians, medical groups, clinics, and other suppliers of covered medical items and services. The information must be arranged in alphabetical order by surname or trade name and made available for public inspection.

The carrier will total all information pertaining to each physician or supplier's own provider identification number for the entire calendar year. A physician may have one identification number as a solo practitioner and one or more as a member of a group or groups, or clinics. If the claims were priced using the fee profile of a medical group or clinic, the name of the medical group or clinic will be used on the list.

The following information will appear on the list for each physician, medical group, clinic, or supplier:

1) Full name of the physician or supplier associated with the provider identification number in the carrier's records.
2) Address of the physician or supplier.
3) Net amount paid on assignment to that physician or supplier during the preceding calendar year. This would show the amount paid directly to that physician or supplier plus or minus any adjustments which were made during the calendar year.
4) Net amount paid to patients (beneficiaries) during the preceding calendar year for services or supplies reported to have been furnished by that physician or supplier. This amount would also show any adjustments made to patients' records during the calendar year concerning that physician or supplier.

*No other information or categorization of data will be included on the Physician or Supplier List.*

Before a list of compiled information can be released for public inspection, a copy of the information on the list and an explanation of the information will be furnished to each physician or supplier. This will give the physician or supplier an opportunity to review the information and to inform the carrier of any apparent discrepancies.

A letter will be sent to each physician or supplier, advising him or her of the information that the carrier has compiled, and also of the 30 day period for requesting clarification of any discrepancies.

## Change in Participation and Location of Labs

Notice was received from the Bureau of Health Insurance office, Social Security Administration of the following changes in participation and location of laboratories in the Medicare program.

Ceased operations:
Central Bio Medical Laboratory
318 Madison St.
Maywood, Illinois 60153
Provider Number: 14-8329
Effective Date: December 1, 1977

(No Longer Performing Diagnostic Testing):
Cos Building Laboratory
2500 Ridge Avenue
Evanston, Ill. 60201
Provider No. 14-8007
Effective Date: October 1, 1977

Approved for Participation:
Liberty Portable X-Ray
5239 South Major
Chicago, Illinois 60638
Provider Number: 14-9816
Effective Date: July 25, 1977

Change in Laboratory Location:
Brooks Clinical Laboratory has relocated to
4013 Milwaukee Ave., Suite 323
Chicago, Ill. 60641
Provider No. 14-8025
Effective Date: October 1, 1977



# the view box

Leon Love, M.D./Chairman/Department of Radiology
Loyola University Stritch School of Medicine

This patient was a 45-year-old white female who came in complaining of shortness of breath and cough.



Figure 1



Figure 2

## *What's your diagnosis?*

1. Miliary tuberculosis
2. Lymphangtic spread of a carcinoma
3. Disseminated histoplasmosis
4. Viral pneumonitis

*(Continued on page 169)*

# Obituaries

°**Baumann, Franz,** Chicago, died December 9 at the age of 81. Doctor Baumann was a 1922 graduate from the University of Baden in Germany.

°**Fullerton, Willard Wilson,** Sparta, died January 1 at the age of 69. Doctor Fullerton was a 1934 graduate of the University of Illinois. He was a Councilor (Trustee) of the ISMS from the 10th District in the 1950s.

°°**Goldberg, Charles,** Chicago, died December 14 at the age of 83. Doctor Goldberg was a 1919 graduate of the Stritch School of Medicine.

°°**Greene, J. Major,** Chicago, died January 4 at the age of 77. Doctor Greene was a 1927 graduate of Rush Medical College.

°°**Hutchison, Roy M.,** Tallahassee, Florida, formerly of Chicago, died December 8 at the age of 93. Doctor Hutchison was a 1913 graduate of Bennett Medical College.

°**Johnson, Mary Bear,** Riverside, died January 12 at the age of 68. Doctor Johnson was a 1940 graduate of Washington University in St. Louis, Mo.

°**Rothman, William,** Chicago, died January 2 at the age of 78. Doctor Rothman was a 1925 graduate of the Chicago Medical School.

°**Turner, Samuel J.,** Chicago, died December 29 at the age of 71. Doctor Turner was a 1934 graduate of the University of Illinois.

**Vaughn, Arkell M.,** Chicago, died on January 4 at the age of 82. Doctor Vaughn graduated from Rush Medical College in 1925 and practiced surgery at Mercy Hospital in Chicago, where the intern-resident alumni named him man of the year in 1963.

Doctor Vaughn, who served as president of the Illinois State Medical Society in 1952, was the author of more than 65 articles published in medical and scientific journals. He taught at the Cook County Gradaute School of Medicine and was also an associate clinical professor of surgery at the Loyola University Stritch School of Medicine.

°*Indicates ISMS member.*
°°*Indicates member of the ISMS Fifty Year Club.*

# ISMS Travel Program

Three of the ISMS travel programs scheduled for 1978 remain open for reservations. These include trips to Scandinavia (July 2-15); Imperial Europe (Aug. 30-Sept. 9) and the Eastern Mediterranean Air/Sea Cruise (Oct. 25-Nov. 7).

Descriptive brochures will be mailed five months in advance. Reservations cannot be accepted without the official form printed in these brochures. Individuals outside a member's immediate family will be placed on standby status until all ISMS members have had reasonable time to make reservations. *Promotional expenses connected with these programs are paid for by the tour operator.* For further information, contact ISMS headquarters.



**Cardilate** (erythrityl tetranitrate)
INDICATIONS For the prophylaxis and long treatment of patients with frequent or recurrent anginal pain and reduced exercise tolerance associated with angina pectoris rather than the treatment of the acute attack of angina pectoris since its onset is somewhat slower than that of nitroglycerin

PRECAUTIONS As with other effective nitrates some fall in blood pressure may occur with large doses

Caution should be observed in administering drug to patients with a history of recent cerebral hemorrhage because of the vasodilation which occurs in the area Although therapy permits more normal activity, the patient should not be allowed to misinterpret freedom from anginal attacks as a signal to drop all restrictions

SIDE EFFECTS No serious side effects have been reported In sublingual therapy, a tingling sensation (like that of nitroglycerin) may sometimes be noted at the point of tablet contact with the mucous membrane If objectionable this may be mitigated by placing the tablet in the buccal pouch As with nitroglycerin or other effective nitrites, temporary vascular headache may occur during the first few days of therapy This can be controlled by temporary dosage reduction in order to allow adjustment of the cerebral hemodynamics to the initial marked cerebral vasodilation These headaches usually disappear after one week of continuous therapy but may be minimized by the administration of analgesics

Mild gastrointestinal disturbances occur occasionally with larger doses and may be controlled by reducing the dose temporarily

HOW SUPPLIED 10 mg chewable scored tablets in bottle of 100 Also 5 10 and 15 mg oral/sublingual scored tablets in bottles of 100 10 mg oral/sublingual scored tablets also supplied in bottles of 1,000

Also available Cardilate®-P brand Erythrityl Tetranitrate with Phenobarbital® Tablets Sc
(®Warning may be habit forming)

Wellcome
Burroughs Wellcome
Research Triangle Pa
North Carolina 277



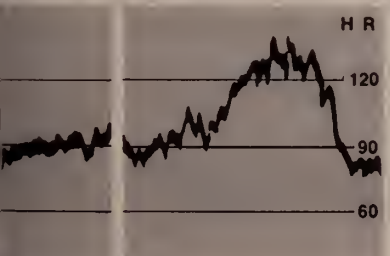
"**Our sex life is nil...**" A problem of the first magnitude to many post infarct patients and their mates...patients are often reluctant to broach the subject; physicians may frequently overlook its implications. This new 16mm film combines candid patient interviews with discussions by Drs. Herman Hellerstein, Thomas Hackett, Albert Kattus, Richard Stein, Carroll Witten and Lenore Zohman. Film and related monograph comprise 2 AAFP credit hours. To arrange viewing, write Burroughs Wellcome Co., Educational Services Department, Research Triangle Park, N.C. 27709 or contact your B.W. Co.® representative.

# Sex and the heart patient:

## A film every doctor should see.

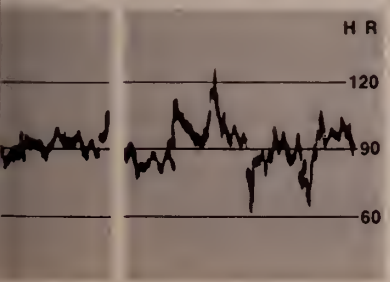
**nergy cost of sex to the is relatively modest.**
30% of post-coronary patients timately resume sexual activity ut serious risk. Hellerstein and man demonstrate that mean nal heart rate during orgasm pouse (as opposed to extra- l sex) in 14 post-infarct pa- s lower than that during usual national activity.

**sentations below of actual readings of an attorney, post ustrate the point:**




ng in office t 90 /min)

B. Confrontation in judge's chamber (about 125 beats/min)




rgasm sex ty (about ats/min)

D. Peaks at orgasm (120 beats/min)



**Fear of pain greatest deterrent to post MI sex**
In the multitude of MI patients with angina, pain is due to diminished coronary reserve and increased myocardial oxygen demand, precipitated by sex, other excitement and improper exercise. Anginal pain, however, can be relieved, and its recurrence mitigated.

**Cardilate® (erythrityl tetranitrate) increases exercise tolerance.**
Cardilate relieves anginal pain and prevents its recurrence, thereby allowing increased activity.
Commencing to work in as little as 2 to 5 minutes, Cardilate protects against recurrence of angina for at least 2 hours.

Available in both sublingual and chewable forms. Cardilate is a versatile, convenient agent to help make the angina patient's life more livable

# Cardilate®
## (erythrityl tetranitrate)

## Rush University 1978 Programs in Education for Practicing Health Professionals

| Date<br>Course Director | Course Title<br>CME Credit | Audience |
|---|---|---|
| January 13, 1978<br>J. Galante, M.D. | Current Concepts in Diagnosis & Treatment of Malignant Bone Tumors<br>7 Hours, Category 1 | Orthopedic Surgeons, Oncologists, Pathologists |
| March 18-19, 1978<br>J. S. Hyde, M.D.<br>Illinois Society of Allergy & Clinical Immunology | Clinical Applications Allergy/Immunology in Primary Care<br>9 Hours, Category 1 | Allergists, Immunologists Internists, Pediatricians, Family Physicians |
| March 18, 1978<br>A. Rossof, M.D.<br>Rush Cancer Center | Cancer & Nutrition Symposium<br>8 Hours, Category 1 | Oncologists, Nurses, Internists, Family Physicians |
| March 18, 1978<br>Max Sadove, M.D.<br>C. Thomason, CRNA | Anesthesia Clinical Update<br>8 Hours, Category 1 | Anesthesiologists, CRNA's |
| March 20, 21, 1978<br>J. Messer, M.D. | Decisions in Cardiovascular Practice<br>14 Hours, Category 1 | Internists, Family Physicians, Cardiologists, Surgeons |
| March 24-25, 1978<br>J. Cavanaugh, M.D.<br>Society for Psychiatry & Law | Forensic Psychiatry Update<br>12 Hours, Category 1 | Psychiatrists, Attorneys, Health Analysts, other Physicians |
| March 30-April 1, 1978<br>W. Weiner, M.D. | Scientific Aspects Neurology Board Review & Update<br>20 Hours, Category 1 | Neurologists, Psychiatrists |
| April 28, 1978<br>Margo Mansfield, O.T. | Medical Audit in Occupational Therapy<br>6 Hours, C.E.U.O.T. | Occupational Therapists |
| April 29, 1978<br>R. DeWald, M.D.<br>M. Faut, R.N. | Scoliosis: School Screening<br>C.E.U. and A.N.A. Credit | School Health Nurses<br>Physical Education Teachers |
| May 12, 1978<br>Y. Adler, M.D. | Pathways to Increased Productivity for Career Women in Academic Health Institutions<br>Category 1 and C.E.U. | Issue-oriented Physicians |
| May 18, 1978<br>A. Rossof, M.D.<br>Rush Cancer Center | Charles Perlia, M.D.<br>Breast Cancer Symposium<br>8 Hours, Category 1 | Family Physicians, Internists, Surgeons, Oncologists |
| May, 1978<br>M. Cohen, M.D.<br>D. Vidaver Cohen, M.A. | The Physician as Writer, A Study of Major Authors: Anton Chekov, William Carlos Williams, Carlo Levi, Mariana Azuela<br>12 Hours, Category 1 | Physicians who are seeking "liberal" studies |
| June-July, 1978<br>P. Anderson, M.D.<br>E. Brueschke, M.D. | Family Practice Review Course<br>Approx. 30 Hours, Category 1 and A.A.F.P. | Family Physicians, Board Review |
| September 9, 1978<br>R. Schenck, M.D. | Treatment of the Injured Hand<br>8 Hours, Category 1 | Plastic, Orthopedic, General Surgeons, Occupational Medicine |
| September, 1978<br>R. Damptz, M.D.<br>Gracia Guise, B.S., M.S. | Issues of Diagnosis in Child Psychiatry<br>6 Hours, Category 1 and C.E.U. | Psychiatrists, Clinical Psychologists, Social Workers, Mental Health Workers |
| October or November, 1978<br>M. Fisher, M.D. | New Approaches in Clinical Electromyography<br>Category 1 | Physicians who are electromyography practitioners |

Most courses are on campus. Some are in downtown hotels. All courses require registration.

**FOR FURTHER INFORMATION PLEASE WRITE:** **Harold A. Paul, M.D., M.P.H.**
**Associate Dean**
**Office of Continuing Education**
**600 S. Paulina Street**
**Chicago, Illinois 60612**

**OR CALL:** **(312) 942-6917**

"Revelation of a second death, and new animal studies, indicate Laetrile can cause fatal poisoning...Georgia researchers will test laser beams for arthritis treatment...In Alabama, a vaccine for protection against dental caries is being studied...New York and Swedish clinicians unveil two noninvasive screening methods for detection of breast cancer..."

**Important things are happening that you should know about right away. You'll find them on your desk every two weeks in Medical World News, the newsmagazine of medicine.**

**Read this one first.**

**medical world news**

A McGraw-Hill publication



# Professional Liability

*It is sometimes reassuring to find that today's woes were also yesterday's laments. This column will reprint verbatim a series of articles which were initiated in the September, 1914, IMJ. Historical perspectives on a modern problem might prove enlightening.*

## MR. FOLONIE'S ARTICLES.

Beginning with this number we will have a series of articles written by Robert J. Folonie, LL.B., on Actions for Civil Malpractice.

Mr. Folonie is attorney for the Medico-Legal Committee of the Illinois State Medical Society. He has had a vast experience in this line as legal counselor for other liability and insurance companies, and anything coming from his pen on this subject is considered authority.

We are exceedingly glad to get these articles, and know that the readers of the JOURNAL will be interested in them. Furthermore, we think they will be the means of preventing some of the ever-increasing number of malpractice suits started against physicians.

## ACTIONS FOR CIVIL MALPRACTICE.

ROBERT J. FOLONIE, LL.B.,
CHICAGO, ILL.

When a newly built vessel glides down the ways, the ship carpenter takes justifiable pride in the newly born ship and in the consciousness that his work is well done. He knows too, that in seasons to come, the vessel will from time to time return to the repair dock to be overhauled, to have her seams caulked, her hull painted, and rotten planks replaced,—and this, whether or not she has shown signs of weakness. He knows too, that if she meets with stress and strain and her existence is threatened by the elements, that salvors, with proper equipment, will exert every effort to save her; for the reward of the salvor is high.

When a tiny new sail is raised on the sea of life, the physician may be certain that the craft he has helped launch will not return while breezes blow fair, but will come to the repair dock only when seams are sprung, oakum knocked out, or masts carried away. He knows she will be poorly sailed, and badly handled, and if he undertakes the work of a salvor, instead of being doubly rewarded, he often meets the claim that he used—not a caulking-iron to pack her seams, but a brace and bit to founder her.

One of the most harassing experiences a physician may anticipate as a possible attendant of his profession is a suit for claimed malpractice. The higher his professional ideals, the greater will be his shock and chagrin when the accusation is made. The wider his reputation and the greater his clientele, the more likelihood there is that he will be made a target for such claims.

It is but rarely that the lawyer is sued for neglect of his clients' interests, while the clergy man when sued at all finds the causes in a complete departure from the clerical field into "primrose fields of dalliance."

Physicians are frequently sued for claimed malpractice, and it seems rather strange at first blush that they should be specially selected from among the learned professions as victims of what most often proves to be a mistaken or malicious claim.

The immunity of the lawyer is somewhat difficult of deduction. It may be that the lawyer so frequently has his fees contingent on results that self-interest is presumed to counteract natural

sloth, or it may be that the lay conception of a lawyer colors the client's mind to such an extent that he hopes little and expects nothing at all, and therefore may never feel the keen shock of disappointment.

The oriental pays his physician while he is well, suspending all payments during ill health. We occidentals view the matter from an entirely variant and essentially barbarous viewpoint. When well we need no physician and need pay him nothing. If we become ill and recover it is due to personal superiority that disease is overcome. Either we are unusually robust and "wore out the illness" or at a critical point, we used elderberry tea, thought healing or mustard plasters, and at once things took a turn for the better. The ministrations of the doctor had little if any, part in the recovery and there is no reason why he should be paid.

If we do not speedily recover it is the fault of the physician, for we are manifestly different from all other patients—more robust—more intelligent—our ailments more interesting.

If disease is not arrested—or leaves painful or disagreeable results, the physician not only should not be paid, but should be sued for malpractice.

Baseless claims of malpractice most often have their genesis in:

(1) *Ignorance*—which classes indiscriminately as cure-alls—thought cures, electricity, massage, radium, medicines, X-rays, and spring waters (preferably hot or nauseous); which believes preventive medicine is an interchangeable arm for filtered water; which regards the physician as a free public servant, employing the agencies of an Indian medicine man, witches' brews and bottled lightning.

(2) *Cupidity*—usually coupled with ignorance and receiving its impetus from the urgings of briefless or unscrupulous lawyers, the jealousy of a fellow-physician, or the prompting of a layman who "was cured of identically the same trouble by Dr. X."

(3) *Delusions—either insane or hypochondriacal,* leading to more or less logical belief that great wrongs have been suffered, or injury has been intentionally inflicted.

Attempt will be made in future articles to discuss malpractice cases more or less clinically with a view to making clear the causes for their being and the attitude of the physician, with a view to minimizing their number. ◄


IMMEDIATE OCCUPANCY

park west medical plaza

An Original Concept

*A one story medical and dental building with private entrances for each suite and ample, adjacent parking. A landscaped environment emphasizing your identity and ease of access for patients.*

SUPERB LOCATION

- *Near downtown Highland Park.*
- *3 minutes from Highland Park Hospital.*
- *One block from Skokie Highway*

UNIQUE FEATURES

- *Individual thermostatic controls in all suites.*
- *Private Toilets*

OUTSTANDING ENVIRONMENT

- *A totally efficient and relaxed atmosphere.*
- *The outstanding medical building in the Chicago area.*

COMPLETE DESIGN FLEXIBILITY

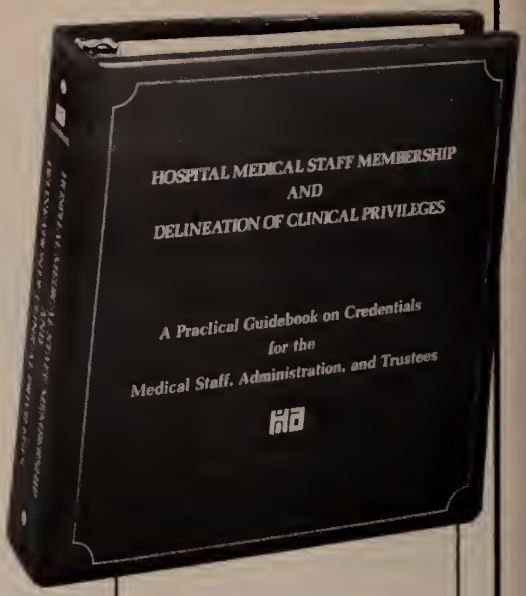
- *Architect designed and built to suit you.*
- *Easy installation of any facilities within suites.*

For Leasing Information Contact:

Milico Development Co. 5500 W. Touhy Avenue Skokie, Illinois 60076 (312) 674-7033

## *A UNIQUE NEW PUBLICATION*

**A publication of the Illinois Hospital Association, prepared in cooperation with The Illinois State Medical Society.**




# HOSPITAL MEDICAL STAFF MEMBERSHIP AND DELINEATION OF CLINICAL PRIVILEGES

***A Guidebook For The Hospital Medical Staff, Administrator and Board of Trustees***

GUIDEBOOK COORDINATOR: Richard E. Thompson, M.D., Author of AUDIT/MCE: A GUIDEBOOK FOR THE HOSPITAL COMMITTEE

**163 PRACTICAL, CLEARLY WRITTEN PAGES INCLUDING:**

- Why credentialing is necessary
- Roles of Medical Staff, Governing Board, Administration, and the Applicant
- "Helpful Hints" on effectively communicating in sensitive areas
- Criteria for considering negative decisions
- Special situations in credentialing, such as the non-physician practitioner
- Detailed procedural checklist for:
  - Initial Medical Staff Appointment
  - Delineation of Clinical Privileges
  - Reappraisal/Re-appointment
- Numerous examples, sample forms and letters
- Appendix includes related standards of the Joint Commission on Accreditation of Hospitals (JCAH)

**TO ORDER YOUR COPY, FILL IN AND MAIL THIS FORM**

**illinois hospital association**
**1200 Jorie Boulevard**
**Oak Brook, Illinois 60521**

Please send _____ copies of HOSPITAL MEDICAL STAFF MEMBERSHIP AND DELINEATION OF CLINICAL PRIVILEGES GUIDEBOOK @ $24.95 each (6 or more in same shipment, $19.95 each)
Also send _____ copies of AUDIT/MCE GUIDEBOOK @ $19.95 each
(6 or more copies in same shipment, $15.95 each)
_____ copies of 1977 Update for the Audit/MCE Guidebook @ $7.50 each.
Make checks payable to: Illinois Hospital Research and Educational Foundation.

NAME _____

TITLE _____

ORGANIZATION _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

( )Bill me ( )Payment enclosed $_____

( )Bill my organization, P.O. No.:




**"I'm just a shadow of what I used to be."**

That is what depressed individuals may feel is the substance of their being. There is no pleasure, no joy — nothing grows — and in the cold shadow of depression their activities are inhibited, while initiative may be eroded or destroyed. The tragedy is that they can see that others are able to live on the brighter side but they, themselves, cannot reach it on their own.

Your experience in treating depression, and Tofranil-**PM** can help light the way.

Tofranil-**PM**®
imipramine **pamoate**

Geigy

Unsurpassed effectiveness among tricyclics in relieving symptoms of anxious depression.

Before prescribing Tofranil-PM, please review a summary of the prescribing information on the back of this page.

# Tofranil-PM®
imipramine **pamoate**

Geigy

As anxiety, agitation, sleep disturbances, and other depressive symptoms are relieved, mood and motivation may be markedly improved.

Patients are usually alert and capable of functioning at more normal levels of behavior.

Tofranil-PM encourages patient compliance because one capsule lasts from bedtime to bedtime.

Good results are usually seen at the starting dose of one 75-mg capsule h.s.

For many patients, dosage can be safely increased to 150 mg daily.

As with all tricyclics, sedation may occur. Please caution patients against driving or operating dangerous machinery.

Each capsule contains imipramine pamoate equivalent to 75, 100, 125 or 150 mg of imipramine hydrochloride.

**Tofranil-PM®**
**brand of imipramine pamoate**

**Indications:** For the relief of symptoms of depression. Endogenous depression is more likely to be alleviated than other depressive states.

**Contraindications:** The concomitant use of monoamine oxidase inhibiting compounds is contraindicated. Hyperpyretic crises or severe convulsive seizures may occur in patients receiving such combinations. The potentiation of adverse effects can be serious, or even fatal. When it is desired to substitute Tofranil-PM, brand of imipramine pamoate, in patients receiving a monoamine oxidase inhibitor, as long an interval should elapse as the clinical situation will allow, with a minimum of 14 days. Initial dosage should be low and increases should be gradual and cautiously prescribed. The drug is contraindicated during the acute recovery period after a myocardial infarction. Patients with a known hypersensitivity to this compound should not be given the drug. The possibility of cross-sensitivity to other dibenzazepine compounds should be kept in mind.

**Warnings:** *Usage in Pregnancy:* Safe use of imipramine during pregnancy and lactation has not been established; therefore, in administering the drug to pregnant patients, nursing mothers, or women of childbearing potential, the potential benefits must be weighed against the possible hazards. Animal reproduction studies have yielded inconclusive results. There have been clinical reports of congenital malformation associated with the use of this drug, but a causal relationship has not been confirmed.

Extreme caution should be used when this drug is given to:

—patients with cardiovascular disease because of the possibility of conduction defects, arrhythmias, myocardial infarction, strokes and tachycardia;
—patients with increased intraocular pressure, history of urinary retention, or history of narrow-angle glaucoma because of the drug's anticholinergic properties;
—hyperthyroid patients or those on thyroid medication because of the possibility of cardiovascular toxicity;
—patients with a history of seizure disorder because this drug has been shown to lower the seizure threshold;
—patients receiving guanethidine or similar agents since imipramine may block the pharmacologic effects of these drugs.

Since imipramine may impair the mental and/or physical abilities required for the performance of potentially hazardous tasks such as operating an automobile or machinery, the patient should be cautioned accordingly.

*Usage in Children:* Tofranil-PM, brand of imipramine pamoate, should not be used in children of any age because of the increased potential for acute overdosage due to the high unit potency (75 mg., 100 mg., 125 mg and 150 mg.). Each capsule contains imipramine pamoate equivalent to 75 mg., 100 mg., 125 mg. or 150 mg. imipramine hydrochloride.

**Precautions:** It should be kept in mind that the possibility of suicide in seriously depressed patients is inherent in the illness and may persist until significant remission occurs. Such patients should be carefully supervised during the early phase of treatment with Tofranil-PM, brand of imipramine pamoate, and may require hospitalization. Prescriptions should be written for the smallest amount feasible.

Hypomanic or manic episodes may occur, particularly in patients with cyclic disorders. Such reactions may necessitate discontinuation of the drug. If needed, Tofranil-PM, brand of imipramine pamoate, may be resumed in lower dosage when these episodes are relieved. Administration of a tranquilizer may be useful in controlling such episodes.

Prior to elective surgery, imipramine should be discontinued for as long as the clinical situation will allow.

An activation of the psychosis may occasionally be observed in schizophrenic patients and may require reduction of dosage and the addition of a phenothiazine.

In occasional susceptible patients or in those receiving anticholinergic drugs (including antiparkinsonism agents) in addition, the atropine-like effects may become more pronounced (e.g., paralytic ileus). Close supervision and careful adjustment of dosage is required when this drug is administered concomitantly with anticholinergic or sympathomimetic drugs.

Avoid the use of preparations, such as decongestants and local anesthetics, which contain any sympathomimetic amine (e.g., adrenalin, noradrenalin), since it has been reported that tricyclic antidepressants can potentiate the effects of catecholamines.

Patients should be warned that the concomitant use of alcoholic beverages may be associated with exaggerated effects.

Both elevation and lowering of blood sugar levels have been reported.

Concurrent administration of imipramine with electroshock therapy may increase the hazards; such treatment should be limited to those patients for whom it is essential, since there is limited clinical experience.

**Adverse Reactions:** Note: Although the listing which follows includes a few adverse reactions which have not been reported with this specific drug, the pharmacological similarities among the tricyclic antidepressant drugs require that each of the reactions be considered when imipramine is administered.

*Cardiovascular:* Hypotension, hypertension, tachycardia, palpitation, myocardial infarction, arrhythmias, heart block, stroke, falls.

*Psychiatric:* Confusional states (especially in the elderly) with hallucinations, disorientation, delusions; anxiety, restlessness, agitation; insomnia and nightmares; hypomania; exacerbation of psychosis.

*Neurological:* Numbness, tingling, paresthesias of extremities; incoordination, ataxia, tremors; peripheral neuropathy; extrapyramidal symptoms; seizures, alterations in EEG patterns; tinnitus.

*Anticholinergic:* Dry mouth, and, rarely, associated sublingual adenitis; blurred vision, disturbances of accommodation, mydriasis; constipation, paralytic ileus; urinary retention, delayed micturition, dilation of the urinary tract.

*Allergic:* Skin rash, petechiae, urticaria, itching, photosensitization (avoid excessive exposure to sunlight); edema (general or of face and tongue); drug fever; cross-sensitivity with desipramine.

*Hematologic:* Bone marrow depression including agranulocytosis; eosinophilia; purpura; thrombocytopenia. Leukocyte and differential counts should be performed in any patient who develops fever and sore throat during therapy; the drug should be discontinued if there is evidence of pathological neutrophil depression.

*Gastrointestinal:* Nausea and vomiting, anorexia, epigastric distress, diarrhea; peculiar taste, stomatitis, abdominal cramps, black tongue.

*Endocrine:* Gynecomastia in the male; breast enlargement and galactorrhea in the female; increased or decreased libido, impotence; testicular swelling; elevation or depression of blood sugar levels.

*Other:* Jaundice (simulating obstructive); altered liver function; weight gain or loss; perspiration; flushing; urinary frequency; drowsiness, dizziness, weakness and fatigue; headache; parotid swelling; alopecia.

*Withdrawal Symptoms:* Though not indicative of addiction, abrupt cessation of treatment after prolonged therapy may produce nausea, headache and malaise.

**Dosage and Administration:** In adult outpatients, therapy should be initiated on a once-a-day basis with 75 mg./day. This may be increased to 150 mg./day which is the dose level which usually obtains optimum response. If necessary, dosage may be increased to 200 mg./day. Dosage should be modified as necessary by clinical response and any evidence of intolerance. Daily dosage may be given at bedtime, or in some patients in divided daily doses.

Hospitalized patients should be started on a once-a-day basis with 100-150 mg./day and may be increased to 200 mg./day. Dosage should be increased to 250-300 mg./day if there is no response after two weeks.

Following remission, maintenance medication may be required for a longer period of time at the lowest dose that will maintain remission. The usual adult maintenance dosage is 75-150 mg./day on a once-a-day basis, preferably at bedtime.

In adolescent and geriatric patients, capsules of Tofranil-PM, brand of imipramine pamoate, may be used when total daily dosage is established at 75 mg. or higher. It is generally unnecessary to exceed 100 mg./day in these patients. This dosage may be given once a day at bedtime or, if needed, in divided daily doses.

**How Supplied:** Tofranil-PM, brand of imipramine pamoate: Capsules of 75, 100, 125 and 150 mg. (Each capsule contains imipramine pamoate equivalent to 75, 100, 125 or 150 mg. of imipramine hydrochloride.)

(B) 98-146-840-A(9/75) 667120

**For complete details, including dosage and administration, please refer to the full prescribing information.**

GEIGY Pharmaceuticals
Division of CIBA-GEIGY Corporation
Ardsley, New York 10502

Printed in U.S.A. (10-77) TO 12889

# Guest Editorial

## *Who's Crying Waste? Why, The Last Of The Big Spenders!*

Officials of our fiscally potbellied federal government feel perfectly free to call the kettle black.

HEW Secretary Joseph Califano told the June AMA convention that "reasonable cost has not been the strong suit of either American medicine or most of its physicians."

But as suggested by an AMA delegate from the state of Washington, the wording could well be changed to: "Reasonable cost has not been the strong suit of either *American government* or its *politicians.*"

In Secretary Califano's own bailiwick, how was economic rationality served by HEW's having to spend a reported $750,000 to redo its incredibly botched-up list of high Medicare payees?

There are plenty of other vivid examples of the federal government's ineligibility to preach economizing—to physicians or anyone else. Here are a few:

* Sen. William Proxmire (D.-Wis.) has deplored the "fleecing" of taxpayers for such undertakings as an $84,000 study to determine why people fall in love; a $27,000 analysis of why prison inmates want to escape (not *how,* mind you, but *why*); a $46,000 inquiry into how long it takes to cook breakfast (including the boiling time for three-minute eggs?); and not less than $3,400,000 for a Madison Avenue advertising campaign to stimulate letter-writing, plus $775,000 to test the campaign results. Assuming that Americans were suddenly stirred to become better pen pals, how well would the extra hills of mail be delivered?

* Sen. Barry Goldwater (R.-Ariz.), in his recent book *The Coming Breakpoint,* cites such "bureaucratic projects" as a $20,000-a-year study of German cockroaches (aren't American good enough?); a $70,000 analysis of the smell of Australian aborigine sweat; and a university-compiled dictionary of witchcraft, by courtesy of a $46,089 federal grant.

* Also, according to Goldwater, an award of $500 was paid out of taxes for a one-word poem: "lighght." Not a lot of money, admittedly, but a lot per letter!

Rising medical and hospital costs are a problem we must face and are facing—through commissions and other formal initiatives within our AMA federation. But government "solutions" to the problem would be like using mosquitoes to fight yellow fever. The public should be told.

**AMA**

# Kefzol® I.M./I.V.
## cefazolin sodium

Ampoules, equivalent to 500 mg., 1 Gm.,
and 10 Gm. of cefazolin




Additional information available
to the profession on request.
Eli Lilly and Company
Indianapolis, Indiana 46206

700773

IMJ
Illinois Medical Journal
Vol. 153, No. 2, February, 1978

# Drug Pharmacokinetics in Patients with Renal Failure

By T. R. Franson, R.Ph., and E. T. Sorensen, M.D./Rockford

Use of pharmacologic agents in patients with renal failure is a challenging and difficult endeavor that requires an appreciation for many pharmacokinetic and pathophysiologic factors.

Patients with renal disease, especially older patients with chronic renal failure, may require drug therapy for both their renal condition and for other associated or unrelated concurrent illnesses. Such individuals have been reported to suffer an increased incidence of adverse drug reactions for many reasons.[1]



T. R. FRANSON, R.Ph., is a fourth-yeor medicol student ot the University of Illinois Rockford School af Medicine. A board certified phormocist, Doctor Franson is now engaged in clinicol reseorch in the Rockford School of Medicine Division of Infectious Diseases, ond is employed as o port-time phormacist.

E. T. SORENSEN, M.D., is a clinicol ossociote professor ot the Rockford School of Medicine ond medical director af the Rockford Memoriol Haspital Dialysis Center. Doctor Sarensen, who specializes in nephrology, is board certified in internal medicine.

As a result of renal impairment, patients are known to excrete drugs entirely or partly unchanged by the kidneys at a slower rate than normal individuals. In addition, an increasing number of pharmacokinetic alterations associated with renal failure, involving properties of drug absorption, binding, distribution and metabolism, have been reported in current literature.

It is necessary to formulate methods for approaching therapy based on the degree of renal impairment and specific drugs for individual patients. The intent of treatment is tò achieve adequate therapeutic blood and urine levels while precluding drug accumulation and adverse reactions.

As a guideline for drug therapy in renal failure, Anderson and colleagues[2] suggest the following:

- drugs should not be used unless definite indications are present;
- dosage regimens of drugs that have been determined in well-controlled studies

should be followed in preference to general formulas;

- in a situation where a drug has not been studied but some information on its characteristics is available (such as percent excretion renally in unchanged form) general formulas may be used to obtain a rough estimate of proper dosage;
- if an assay procedure for a drug is available, periodic blood level determinations of the drug are advisable; and
- careful clinical monitoring for toxicity and pharmacological effect is always mandatory.

Dettli also suggests that the following therapeutic postulate be fulfilled: "The drug level resulting in the patient with renal disease should be the same and should be reached after a similar time interval as in patients with normal renal function."[3]

In the following text, pharmacokinetics in the normal and uremic patient will be discussed, followed by a review of principles for selecting drug dosage regimens in renal failure.

## Pharmacokinetics: An Overview

Drugs may be processed by the body in a variety of ways. The mode depends upon the intrinsic characteristics of individual pharmacologic agents, such as degree of protein binding and normal volume of distribution. A drug may also be metabolized through mechanisms such as oxidation, reduction, conjugation or acetylation with resultant active and/or inactive metabolites, or conversely may be subject to no metabolic alterations. The kidney receives metabolized or non-metabolized products which may be handled by glomerular filtration, active reabsorption and/or tubular secretion, or by nonionic back diffusion. Renal clearance is also influenced by the extent to which a drug is bound by plasma proteins.

In the uremic patient, several alterations in the above patterns have been observed.

From data available, it appears that renal failure has little adverse effect upon oral or intramuscular absorption of most drugs, with the notable exception of Vitamin D and iron malabsorption.[4]

Changes in the volume of distribution ($V_D$) of drugs in the body have been observed in renal impairment. Generally, drugs which are not highly protein bound and/or highly lipid soluble have a larger $V_D$. In renal failure, however, drug redistribution may result in concentration of a drug in the central compartment at the expense of that in the tissue compartment.[5] For example, azotemic patients may exhibit a lowered myocardium:serum concentration ratio for digoxin, which relates to decreasing creatinine clearance values, and these changes correspond with the distribution differences observed between normal and uremic patients.[6]

Decreased binding capacity of many drugs to plasma proteins has been observed in patients with renal failure as opposed to normal subjects, and most of the drugs exhibiting abnormal binding are organic acids (including sulfonamides, thyroxine, phenytoin and clofibrate).[6,7] Drugs which are organic bases appear to bind normally in plasma from uremic patients, with the exception of triamterene.[7] One neutral compound, digitoxin, has been shown to have decreased binding capacity in the plasma from uremic patients.[7] Reduced plasma protein drug binding can be expected to result in a greater tissue distribution, a higher apparent $V_D$ and a lower plasma concentration of drug.[6] Therefore, uremic patients may respond to some forms of drug therapy at relatively lower total plasma concentrations than non-uremic patients. Binding changes are greater than can be accounted for by hypoalbuminemia alone,[7] and current evidence suggests the possibility of a binding inhibitor in uremic patients that has not yet been characterized.[8] Changes in protein binding have been demonstrated to be transferred in the protein, but not in ultrafiltrate fraction of uremic serum. One study has shown that the addition of relatively large amounts of creatinine, urine, uric acid, phosphate, and excessive quantities of suspected uremic toxins (such as methylguanide, guanidinosuccinic acid, and guanidinoacetic acid) to normal serum failed to produce a binding defect for sulfamethoxazole.[8] A study using five different drugs found that charcoal treatment of uremic serum corrected binding defects.[8] Rapid correction of binding defects after successful kidney transplant also has been observed. The above data provides strong support for the concept of a binding inhibitor, which has been postulated to either occupy certain drug binding sites, change the configuration of the albumin molecule, or both.[8] Inability of dialysis to correct such binding defects suggests that the inhibitor may be highly bound to serum proteins. Although free fatty

acids (FFA) are known to strongly bind to serum albumin and affect drug-protein interactions,[9] FFA levels in chronic renal failure are usually low or normal.[10] Further research is necessary to define the nature and characteristics of inhibitor agents.

Most drugs are metabolized to an inactive congener form before excretion. Oxidation and glucuronide conjugation are the major pathways for drug processing, and these appear to function normally in uremic patients.[11] Therefore, most metabolized drugs are not prone to accumulate in renal failure unless excessive doses are used or concurrent metabolic derangement is present. However, minor pathways such as reduction and some acetylation reactions appear slowed in uremia, hence drugs such as p-aminosalicylate, some sulfonamides, and hydralazine are metabolized slowly.[11] Since plasma cholinesterase activity is also decreased in renal failure, ester-type local anesthetics are slowly processed.[11] Drugs which show delayed metabolism are therefore prone to accumulation at normal dosages. It must be noted that the accumulation of pharmacologically active metabolites may also lead to toxic effects.[5] In addition, although most drug metabolities are inactive, their accumulation with repeated dosing may cause toxic reactions by displacing the active parent drug from plasma proteins, and by inhibiting further drug metabolism via end-product inhibition.[5]

## Methods of Measurement

Altered drug removal from the body has been observed in renal insufficiency. Ionic competition for tubular secretion has been noted with both organic acids and bases, although its significance is unclear.[2] Alterations of other renal processing mechanisms are not well defined. The fact that renal failure is associated with impaired elimination of many therapeutic agents is of clinical significance.

Elimination half-time ($t1/2$) is the time required for the amount of drug in the body to decline by one-half. It is a convenient measure to express drug removal either by renal excretion and/or conversion to metabolites, or by extrarenal excretion. The influence of renal failure on drug $t1/2$ is a direct function of the percentage of drug cleared through the kidney, and is also related to the degree of renal impairment in individual patients.[5] The overall elimination rate constant (k) is an expression of the sum of elimination rate constants by extrarenal (knr) and renal (kr) pathways, as shown in the following equation: $k = knr + kr$.[5,12]

Drugs can be classified in three general groups with respect to changes in elimination, as characterized by changes in $t1/2$ and the degree of renal impairment (gauged by endogenous creatinine clearance, $Cl_{cr}$) as follows:[3]

Type A (drugs eliminated almost entirely by the kidneys) : $t1/2$ increases only slightly with decreasing values of $Cl_{cr}$ until a critical value of $Cl_{cr}$ (10-20 ml/min.) is reached, below which $t1/2$ increases dramatically with further decreasing values of $Cl_{cr}$;

Type B (drugs eliminated almost entirely by extrarenal mechanisms) : $t1/2$ remains practically unchanged with decreasing values of $Cl_{cr}$; and

Type C (drugs eliminated partly by the kidneys and partly by extrarenal mechanisms) : $t1/2$ shows a behavior intermediate between Type A and Type B drugs.

It is apparent that drugs cleared only by renal pathways are most influenced by renal failure, and in severe impairment, k approaches zero as $t1/2$ approaches an infinitely large value. For example, studies with Cefazolin, a cephalosporin antibiotic which is primarily cleared by renal mechanisms, have shown that Cefazolin $t1/2$ increases slowly until $Cl_{cr}$ falls below 30 ml/min., then as $Cl_{cr}$ is further reduced, drug $t1/2$ markedly increases.[13] Values for kr and knr are available for some pharmacologic agents based on experimental studies. In many instances such values are not available, however, and drug dosages must be derived from general formulas. When values for kr and knr are available, dosages can be more accurately calculated using standard nomograms and tables.

## Correlating Mechanisms

Disagreement exists as to the appropriate means for relating measures of renal impairment to pharmacokinetic calculations. Many authors advocate endogenous creatinine clearance as a reliable measure of renal impairment in a patient. Several studies have demonstrated a linear relationship between the apparent overall elimination rate constant and renal clearance of endogenous creatinine.[14] Therefore, changes in $Cl_{cr}$ can be correlated with expected changes in drug elimination by consulting appropriate

nomograms. Errors in measuring urine flow and incomplete bladder emptying can frequently result in inaccurate clearance measurements.[15]

The use of serum creatinine measurements in determining anticipated alterations in drug elimination appears to be a less acceptable form of monitoring. A well-defined quantitative relationship between $Cl_{cr}$ and serum creatinine has been demonstrated in patients with stable renal function, and in such patients standard nomograms can be used to calculate drug dosage on the basis of serum creatinine.[3,16] However, the quantitative relationship between $Cl_{cr}$ and serum creatinine is not valid under certain circumstances. These include acute or unstable kidney diseases, elderly patients or those undergoing dialysis, the presence of extremely severe uremia (e.g., serum creatinine greater than 8 mg./100 ml.) or muscular abnormalities influencing endogenous creatinine production, such as cachexia or systemic muscular disease.[17] It also has been shown that drug $t_{1/2}$ will be linearly related to serum creatinine only when knr is very small compared to k. As knr increases, the relationship is curvilinear, and drug $t_{1/2}$ becomes increasingly independent of serum creatinine as knr approaches k.[5] Thus, the dosage of drugs metabolized to any great extent cannot be calculated with formulas using serum creatinine as an indicator of renal function. In addition, serum creatinine does not reflect acute changes in renal function. It has been shown that after an acute loss of renal function to 10% of normal, serum creatinine takes approximately seven days to reach a new stable concentration.[18]

Under certain circumstances, dosage adjustments based on either serum creatinine or $Cl_{cr}$ may not be valid. This can occur, for example, if a drug exhibits very marked multicompartment characteristics. With this type of drug, $t_{1/2}$ is a function not only of drug elimination, but also of drug distribution, and is therefore not linearly related to serum creatinine or $Cl_{cr}$.[15] As an illustration, when benzylpenicillin, a drug with multicompartment distribution, is administered with probenecid, which is known to reduce renal excretion of this penicillin, the change in clearance of benzylpenicillin shows almost a two-fold difference as compared to change in half-life.[15]

In many cases, however, serum creatinine or creatinine clearance levels can be used conveniently to estimate renal impairment in dosage calculations if the aforementioned situations have been considered.

The most accurate method for determining dosages in renal failure involves determining drug concentrations in body fluids. When an assay method in plasma and urine is available, direct evaluation of drug clearance is superior to employing secondary measurements for adjusting dosage regimens in renal failure.[2,15] Assay results may then be used in dosage calculations.

When drugs with a low therapeutic index are used, such as aminoglycoside antibiotics, it is imperative that accurate dosage adjustments be made. Such agents are more prone to accumulation and a greater incidence of adverse reactions than drugs with a high therapeutic index. The concurrent use of agents which display synergistic nephrotoxicity should likewise be undertaken with great caution.

Patients suffering from both impaired renal and extrarenal drug processing mechanisms present uniquely difficult drug management problems. Concurrent derangements in drug metabolism and excretion preclude calculation of dosage regimens by any conventional means, and therapy must be highly individualized.

## Dosage Calculations

Many approaches to the calculation of drug dosage regimens in renal failure have been forwarded in the literature. Several general principles are helpful in understanding these regimens.

All modifications are based on either: (1) an alteration in drug dosage, or (2) a change in dosage interval, or a combination of these two variables. In addition, the use of continuous versus intermittent drug administration plays an important role in dosing decisions.

It is generally agreed that in any dosage regimen, a loading dose is necessary to achieve a steady-state concentration of drug. In normal patients, steady-state drug concentration in serum is only reached after a period of 4-5 half-lives of a drug during repeated administrations. In a patient with renal failure, drug half-life is prolonged, as is the time at which the steady state will be reached.[3,17] Therefore, an initial loading dose is given, followed by appropriate adjustments in either dose or dosage interval. It is most convenient to alter dosage interval with dosage forms such as capsules or tablets.

If one chooses to increase the dosage interval rather than decrease a given dose greater fluctua-

tions in drug concentrations occur. A relatively greater amount of time with lower blood levels of a drug may result. Conversely, if drug dosage is decreased while maintaining a normal dosage interval, concentrations are more constant and do not exhibit such large peaks and valleys.[2]

Dettli[17] has suggested the following dosage rules for continuous and intermittent drug administration. These rules are based on nomograms which correlate renal impairment (as measured by $Cl_{cr}$ or serum creatinine) with changes in drug elimination rate constant and with the percentage of drug excreted unchanged by the kidney.

*Continuous Drug Administration:* normal loading dose is administered, with maintenance dose lowered in proportion to the decrease in the drug's elimination rate constant in patients with renal disease.

*Intermittent Drug Administration:* is much more complex. In most cases, normal loading dose is used, maintenance dose is half the loading dose, and the dosage interval is equal to the individual half-life of the drug as estimated from the patient's creatinine clearance.

In intermittent administration, several other considerations become important. With reversibly acting drugs, such as bacteriostatic antimicrobial agents, drug concentration at the end of dosage intervals should be identical in all patients. By contrast, with irreversibly acting drugs, such as bactericidal antibiotics, concentration "peak" at the beginning of dosage intervals should not vary.

These situations usually require sophisticated monitoring, as by serum antibiotic assays. In some antibiotics such as gentimicin, characterized by identical loading and maintenance dosages, dosage interval calculated by standard means may exceed drug half-life. In this event, Dettli has recommended that normal dosage interval and normal loading dose remain unchanged, and that maintenance dosage be reduced by a dose fraction which is calculated by dividing the usual dosage interval by the estimated drug half-life.[17]

When using the above dosage rules, it is assumed that the physician has access to appropriate tables and nomograms. Experimental studies have determined values, such as percentages for renal clearance and extrarenal processing for various drugs. These values are needed for calculations and can be obtained from several sources. (See Table I)

**TABLE I**

Specific values may not be available for many drugs. In such instances, Anderson and colleagues[2] recommend that dosage regimens be calculated on the following basis:

(1) Drugs excreted 100% unchanged by the kidney

a. Dosage Interval in Renal Failure = Normal Dosing Interval × $\frac{\text{Normal Clcr}}{\text{Patient Clcr, or}}$

b. Dosage in Renal Failure = Normal Dose × $\frac{\text{Patient Clcr}}{\text{Normal Clcr}}$

(2) For metabolized drugs

a. Dosage Interval in Renal Failure = Normal Dosing Interval × $\frac{1}{f(Kf-1)+1, \text{ or}}$

b. Dosage in Renal Failure = Normal Dose × $\frac{f(Kf-1)+1}{1}$

where f is the fraction of absorbed dose which is normally eliminated in unchanged form by the kidney, and $Kf = \frac{\text{Patient Clcr}}{\text{Normal Clcr.}}$

## Dialysis

The influence of hemodialysis on drug half-life depends on many factors. These include blood flow through the dialysis machine, dialysate flow rate, membrane permeability, drug volume of distribution, protein binding, drug molecular weight, and lypophilicity. In general mean half-life during dialysis ranges from 4-8 hours for most dialysable drugs, corresponding to removal of approximately 50% of a drug in the body during a six hour dialysis.[5]

It is apparent that the use of pharmacologic agents in patients with renal impairment is influenced by a great number of variables which complicate therapeutic decisions. The selection of specific drugs, dosage regimens, and monitoring technique for patient therapy in renal impairment must be individualized. The physician must consider both the degree of renal failure and the pharmacokinetic characteristics of each drug in order to maximize therapeutic efficacy while protecting the patient from untoward drug effects. ◄

## References


1. Smith, J. W., Seidl, L. G., and Cluff, L. E.: "Studies on the Epidemiology of Adverse Drug Reactions. V. Clinical Factors Influencing Susceptibility," *Ann. Intern. Med.* 65:629-640, 1966.
2. Anderson, R. J., Gambertoglio, J. G., and Schrier, R. W.: "Fate of Drugs in Renal Failure." THE KID-

NEY, 1st Ed. (Brenner, B. M., and Rector, F. C., eds.) W. B. Saunders, Philadelphia, Pennsylvania, 1976, pp. 1911-1948.
3. Dettli, L. C.: "Drug Dosage in Patients with Renal Disease," *Clin. Pharmacol. Therap.* 16:274-280, 1974.
4. Anderson, R. J., Gambertoglio, J. G., and Schrier, R. G.: "CLINICAL USE OF DRUGS IN RENAL FAILURE," (Introduction) 1st ed. Charles C Thomas, Springfield, Illinois, 1976, pp. 3-20.
5. Welling, P. G., and Craig, W. A.: "Pharmacokinetics in Disease States Modifying Renal Function," THE EFFECT OF DISEASE STATES ON DRUG PHARMACOKINETICS, 1st ed. (Benet, L. Z., ed.) American Pharmaceutical Association, Washington, D. C., 1976, pp. 155-187.
6. Jusko, W. J.: "Pharmacokinetics in Disease States Changing Protein Binding," THE EFFECT OF DISEASE STATES ON DRUG PHARMACOKINETICS, *ibid*, pp. 99-123.
7. Reidenberg, M. M., and Affrime, M.: "Influence of Disease on Binding of Drugs to Plasma Proteins," *Ann. N.Y. Acad. Sci.* 226:115-126, 1973.
8. Craig, W. A., Evenson, M. A., and Ramgopal, V.: 'The Effect of Uremia, Cardiopulmonary Bypass and Bacterial Infection on Serum Protein Binding," THE EFFECT OF DISEASE STATES ON DRUG PHARMACOKINETICS, *op. cit.*, pp. 125-151.
9. Rudman, D., Bixler, T. J., II, and Del Rio, A. E.: "Effects of Free Fatty Acids on Binding of Drugs by Bovine Serum Albumin, by Human Serum Albumin, and by Rabbit Serum," *J. Pharmacol. Exp. Ther.* 176: 261-272, 1971.
10. Losowsky, M. S., and Kenward, D. M.: "Lipid Metabolism in Acute and Chronic Renal Failure," *J. Lab. Clin. Med.* 71:736-743, 1968.
11. Reidenberg, M. M.: "Kidney Disease and Drug Metabolism," *Med. Clin. N. Am.* 58:1059-1062, 1974.
12. Welling, P. G., Craig, W. A., and Kunin, C. M.: "Prediction of Drug Dosage in Patients with Renal Failure using Data Derived from Normal Subjects," *Clin. Pharmacol. Therap.* 18:45-52, 1975.
13. Craig, W. A., Welling, P. G., Jackson, T. C., and Kunin, C. M.: "Pharmacology of Cefazolin and Other Cephalosporins in Patients with Renal Insufficiency," *J. Infect. Dis.* 128 (Suppl.):347-353, 1973.
14. Dettli, L., Spring, P., and Habersang, R.: "Drug Dosage in Patients with Impaired Renal Function," *Postgrad. Med. J.* 46 (Suppl.):32-35, 1970.
15. Perrier, D., and Gibaldi, M.: "Estimation of Drug Elimination in Renal Failure," *J. Clin. Pharmacol.* 13:458-462, 1973.
16. Perrier, D., and Gibaldi, M.: "Serum Creatinine and Drug Half-lives in Renal Failure," *JAMA* 221:918, 1972.
17. Dettli, L.: "Individualization of Drug Dosage in Patients with Renal Disease," *Med. Clin. N. Am.* 58:977-985, 1974.
18. Chiou, W. L., and Hsu, F. H.: "Pharmacokinetics of Creatinine in Man and its Implications in the Monitoring of Renal Function and in Dosage Regimen Modifications in Patients with Renal Insufficiency," *J. Clin. Pharmacol.* 15:427-434, 1975.

★

*Specialized Service*

IN

PROFESSIONAL LIABILITY INSURANCE

*is a high mark of distinction*

THE

MEDICAL PROTECTIVE COMPANY

FORT WAYNE, INDIANA

*Professional Protection Exclusively since 1899*

CHICAGO AREA OFFICE:

T. J. Pandak, J. C. Kunches, L. R. Gannan, and W. G. Prangle, Representatives

814 Cammerce Drive, Suite 101B, Oak Brook, Illinois 60521 (312) 325-7314

SPRINGFIELD OFFICE: W. J. Nattermann, Representative

426½ South Fifth Street, Springfield 62701 (217) 544-2251

# Acutely Disturbed Psychotic Patients Treated With Parenteral Haloperidol

By Randall J. Firling, M.D./Skokie

The following report describes briefly the control of psychosis exacerbation by parenteral haloperidol in 169 patients treated over the past three years at community and custodial institutions. These patients, 124 men and 45 women, were all acutely disturbed, agitated, hostile, and frequently belligerent. The majority (130) were schizophrenic; the others had manic depressive psychoses (20) or a psychosis induced by the abuse of drugs (10). The patients had either stopped taking psychotropic medication (141 reported some previous drug therapy) or had relapsed despite treatment.

One injection of haloperidol 10mg was administered to 125 of the patients. Two to four injections of 10 mg were administered at half hour intervals to another 21 patients. The remainder (23 patients) required only one injection of 5mg. Thirty minutes or less after haloperidol was injected, psychomotor agitation was reduced significantly in 157 patients (93%). Hostility and belligerence were reduced significantly in 136 (81%) (p less than .01 or .05 in Student's t-Test). Related signs and symptoms of psychosis such as auditory hallucinations and flight of ideas (in manic patients) were also reduced in intensity. None of these 169 patients had hypotensive reactions. In 16 patients, extrapyramidal signs developed, notably dystonia (12/16), but these either disappeared or were readily controlled with oral trihexyphenid 2mg.

Haloperidol controlled the signs and symptoms of acute psychosis in these acutely disturbed patients without sedating them to the point where they could not participate in their own therapy. Approximately half (90/169) were returned to their homes following treatment.

One such case that particularly impressed the emergency room staff was a severely disturbed 45-year-old man who heard voices when he was alone, claimed to have been made an honorary citizen of Mexico, and had developed a tremendous financial scheme for that country. This patient was given three intramuscular injections of haloperidol 10mg, a total of 30mg over two hours. Following this, he was calmer and less delusional, and able to talk coherently to his wife and to members of the staff. Seen initially in the emergency room at 9 a.m., he was discharged at 3 p.m. - the same day, on an oral dose of haloperidol 100mg daily. On reexamination of the patient seven days later it was evident that he was stabilized and could continue to remain in the community.

Parenteral haloperidol is the preferred agent in psychiatric emergencies involving agitated, aggressive, hostile patients. It controls disruptive behavior, rapidly modifies disordered thinking, and is less likely to produce cardiovascular effects than agents such as chlorpromazine. A single injection of haloperidol 10mg usually suffices for these patients. Those requiring more than 10mg can be given additional injections at 30 to 60 minute intervals, depending on their response. With this regimen, I have not had occasion to administer more than 40mg of haloperidol intramuscularly to a patient in one day. To maintain optimum therapeutic benefit, treatment with oral haloperidol is begun within three to four hours of the last intramuscular injection, at approximately two to three times the total intramuscular dose administered in 24 hours. ◄



RANDALL J. FIRLING, M.D., is a psychiatrist specializing in psychopharmacology. Doctor Firling's office is located in Racine, Wisconsin, and he practices part-time in Chicago. Doctor Firling received his M.D. from Loyola University Stritch School of Medicine in 1972 and is an assistant professor in Psychiatry at Rush-Presbyterian St. Luke's Medical Center.

# The Detection of Asymptomatic Bacteriuria In Juvenile Diabetes Mellitus

By Richard P. Nelson, M.D., Thomas J. Marr, M.D.
and Howard S. Traisman, M.D./Chicago

*Chronic renal disease is a major determinant of morbidity and mortality in patients with juvenile-onset diabetes. Numerous reports have noted the importance of urinary tract infection in the development of this renal disease, although its precise role is unclear.*[1-3] *Routine surveillance for bacteriuria using traditional culture techniques is cumbersome and expensive in many patient care facilities, which discourages regular evaluation of asymptomatic patients. This study utilizes a convenient urine culture screening technique to assess the incidence of bacteriuria in a population of juvenile diabetics. The data suggest that application of screening methods for bacteriuria may define the relationship of urinary tract infection with subsequent chronic renal disease in these patients.*

One hundred children attending a July, 1974, summer camp for juvenile diabetics were studied. The camp was sponsored by the American Diabetes Association, Greater Chicago Affiliate. There were equal numbers of boys and girls ranging from 8 to 13 years in age. At camp registration each child and his or her parents were asked whether a physician had ever diagnosed a urinary tract infection in the child. The age of the diagnosis, urinary symptoms, and therapy of any infection were also recorded.



HOWARD S. TRAISMAN, M.D., is a pediatrician and attending staff member at Northwestern University Medical Center in Chicago and Evanstan Haspital. A specialist in pediatric endocrinology, Doctor Traisman also serves os professor of pediatrics at Northwestern University Medical School.

THOMAS J. MARR, M.D., is o pediatrician affiliated with Northwestern University Children's Memarial Hospital. Doctor Marr specializes in pediatric nephralagy and is an assistant profassor in clinical pediatrics at Northwestern University Medical Schoal.

RICHARD P. NELSON, M.D., is a clinical fellaw in pediatrics ot the Developmental Evaluotion Clinic, Children's Hospital Medical Center in Bastan, Massachusetts. Doctor Nelsan is olsa a clinical fellow in pediatrics at Harvard University Medical School in Boston. During the years 1975-1976, he was chief pediatric resident at Northwestern University Children's Memarial Hospital ond on instructor at Northwestern University Medicol School.

During the three-week camp period, all children were screened with routine urinalysis and Microstix® culture strips to detect the presence of asymptomatic bacteriuria. Microstix® consist of a clear polysterene strip with two dehydrated culture media pads containing colorless tetrazolium and a nitrate reagent pad attached in series. The tetrazolium, when produced in the presence of bacterial multiplication, causes discrete red spots on the pads which can be quantitated visually to correspond to $10^1$, $10^2$, $10^3$, $10^4$, and $10^5$ bacterial colonies/ml. One of the media pads contains an inhibitor of gram-positive organism enabling the differentiation of a total bacterial count from a gram-negative bacteria count. The method's reliability has previously been demonstrated.[4-6]

The children were instructed to collect a midstream specimen from the first morning void in a sterile plastic container. No special cleansing directions were given. The specimens were brought promptly to the camp infirmary and refrigerated. Within two hours all urinalyses and cultures were performed. After a 24 hour incubation at 38°C the culture strips were interpreted and all children with >50,000 colonies/ml were requested to collect a second specimen. This specimen was cultured not only with Microstix® but also onto blood agar and MacConkey media streak plates. A standard 1:1000 dilution calibrated loop and uncentrifuged urine were employed. All children with greater than 100,000 colonies/ml of pure growth were then recultured to confirm the diagnosis of significant urinary

Table 1
Urine Culture Results in 100 Diabetic Children

| Females | Gram Neg. Colonies/Ml by Microstix® | Number Pts. | Streak Plate Cultures | Repeat Microstix® |
|---|---|---|---|---|
| | $10^3$ or less | 44 | — | — |
| | $10^4$ | 3 | No Growth | No Growth |
| | $10^5$ | 1 | 50,000 col. E. coli | $10^5$ |
| | | 1 | 100,000 col. E. coli | $10^5$ |
| | | 1 | No Growth | No Growth |
| Males | $10^3$ or less | 48 | — | — |
| | $10^4$ | 1 | No Growth | $10^1$ |
| | $10^5$ | 1 | No Growth | $10^1$ |

tract infection prior to beginning antimicrobial therapy.

The children with documented infection were referred, upon conclusion of camp, to their private physician or clinic for re-evaluation following completion of therapy.

## Results

The initial interview revealed that 11 of the 50 girls had a history of at least one urinary tract infection. Three of these girls had a single recurrence. Two of the 50 boys' histories noted a single infection. These were reportedly associated with an obstructive lesion of the lower urinary tract, demonstrated by a urologic procedure. Neither had a recurrence of infection. None of the children had symptoms suggestive of a current urinary tract infection.

The results of the urine culture screening are found in Table 1. Of the 6 girls with $10^4$ colonies/ml or greater (as estimated by the Microstrix® method) only one child had $>10^5$ colonies/ml of pure-growth *E. coli* by streak plate. A second girl had 50,000 colonies/ml of *E. coli* on two successive streak plates. Both children had no previous history of urinary tract infection and were treated with sulfisoxasole. Their bacteriuria cleared in 72 hours. There were no confirmed infections in the boys, including the 2 children with history of previous infection.

The microscopic urinalyses were largely nonproductive although the one child with >100,000 colonies/cc had 5-7 WBC/HFP. No proteinuria was found.

## Discussion

Autopsy studies report a higher incidence of pyelonephritis and other suppurative urinary tract disease in diabetics than in non-diabetics.[1-2] The relationship between histologic renal infection and bacteriologic findings is not clear. Halverstadt performed renal biopsies on 80 juvenile diabetics and could demonstrate no correlation between the renal tissue pathology and the culture data at the time of the biopsy.[3] However, no information is given regarding a prior history of urinary tract infection in these patients and 7 patients (9%) were diagnosed with chronic pyelonephritis on biopsy. If unrecognized urinary tract infection contributes to compromised renal function in the older diabetic, it seems reasonable to be alert for bacteriuria in children with juvenile-onset disease.

Our study, using a screening method, found that 2% (1/50) of the girls had $>10^5$ colonies/ml of a pathogenic organism. An additional child had $10^4$ colonies/ml on reculture. No infections were detected among the boys. This compares with previous studies on the incidence of asymptomatic bacteriuria in diabetic and non-diabetic children using standard bacteriologic methods. Etzwiler, in a study of diabetic patients 6 to 25 years in age, found no infections in 76 males and 1 in 94 females.[7] Similarly, a 1% incidence in girls in a large-scale study of school-age children had been published earlier by Kunin.[8] Pometta reported similar frequency of bacteriuria among a population of juvenile diabetic campers.[9]

Large scale studies designed to assess the incidence of asymptomatic bacteriuria in adults with diabetes have produced conflicting data. O'Sullivan reported no significant difference in the occurrence of urinary tract infection in 150 adult diabetics as compared with controls, although the frequency of infection rose remarkably after 40 years of age.[10] Hansen, however, found an increased incidence of bacteriuria in diabetic women, 18.5% (15/81) as opposed to 3.7% (3/81) in controls.[11] These patients tended to be younger and more evenly distributed in

age than those in O'Sullivan's group. Subsequently, Parrish published the results of a screening of 342 men and 177 women with diabetes showing that 14% of the women but only 2% of men had significant bacteriuria.[12] Nearly three-quarters of the infected women were greater than 60 years of age; 84% had been previously catheterized and 44% had a history of prolapse, bladder or vaginal surgery. The author concluded that these manipulations might be responsible for the prevalence of infections in their diabetic population.

### Cumulative Inferences

Several observations may be made from these studies. The adult male diabetic does not appear to be at greater risk for contracting urinary tract infection than his non-diabetic counterpart. Female diabetics in older age groupings, however, apparently have more asymptomatic bacteriuria. The discrepancy with non-diabetic women may disappear if corrected for a history of urogenital manipulations. The presence of a neurogenic bladder or renal micro-vascular disease may contribute to an increased incidence of urinary tract infection in older diabetic patients.

This study shows that a urine culture screening technique has been found applicable to a group of patients who may be at greater risk for the consequences of unrecognized bacteriuria. There is a 6% false-positive finding on initial culturing of the children. This apparently resulted from contamination, as subsequent reculturing using the Microstix® and standard media showed no significant growth. With a technique so readily adaptable to outpatient clinics, practitioners' offices and camps, screening for bacteriuria in diabetic children has now become more practical and economical. The low rate of false-positives secondary to contamination in collection should not be a major obstacle. The availability of a screening method could foster greater physician awareness of asymptomatic bacteriuria in their young diabetic patients, and clarify the relationship of bacteriuria and chronic renal disease in these patients if careful longitudinal cultures are obtained. ◄

### References


1. Robbins, S. L. and Tucker, A. W.: "The Cause of Death in Diabetics," *New England J. Med.,* 231:865-868, 1944.
2. Young, K. R. and Clancy, C. F.: "Urinary Tract Infections Complicating Diabetes Mellitus," *Med. Cl. N. Amer.* 39:1656-1670, 1955.
3. Halverstadt, D. B., Leadbetter, G. W. and Field, R. A.: "Pyelonephritis in the Diabetic," *JAMA,* 195:139-141, 1966.
4. Craig, W. A., Kunin, C. M. and DeGroot, J.: "Evaluation of New Urinary Tract Screening Devices," *Applied Microbiology,* 26:196-201, 1973.
5. Moffat, C. M., Brett, M. R. and Burke, J. P.: "Evaluation of Miniature Test for Bacteriuria Using Dehydrated Media and Nitrate Pads," *Applied Microbiology,* 28:95-99, 1975.
6. Marr, T. J. and Traisman, H. S.: "Detection of Bacteriuria in Pediatric Outpatients," *Amer. J. Dis. Child,* 129:940-942, 1975.
7. Etzwiler, D. D.: "Incidence of Urinary-Tract Infections Among Juvenile Diabetics," *JAMA* 191:93-95, 1965.
8. Kunin, C. M., Southall, I. and Paquin, A. J.: "Epidemiology of Urinary-Tract Infections," *New Eng. J. Med.,* 263:817-823, 1960.
9. Pometta, D., Ries, S. B., Younger, D. and Kass, E. H.: "Asymptomatic Bacteriuria in Diabetes Mellitus," *New Eng. J. Med.,* 276:1118-1121, 1967.
10. O'Sullivan, D. J., Fitzgerald, M. G., Meynell, M. J. and Malins, J. M.: "Urinary Tract Infection. A Comparative Study in the Diabetic and General Populations," *Brit. Med. J.,* I:786-788, 1961.
11. Hansen, R. O.: "Bacteriuria in Diabetic and Non-Diabetic Outpatients," *Acta Med. Scand.,* 176:721-730, 1964.
12. Parrish, J. A.: "Urinary Infection in Diabetic Outpatients," *Lancet,* II:414-415, 1965.



LEASE NOW

PORSCHE 911

The ultimate sports machine. We have the largest inventory in the midwest.



AUDI 5000

The sensible luxury car. All types of leases available, long or short term.



NOW RESERVING SPRING LEASE DATES FOR PORSCHE 928's!

Doctors have special transportation needs and we have been filling them with incomparable automobiles for years. Leasing your next car makes good economic sense and we'd like to show you why.

O'HARE INTERNATIONAL AUTOS

THE MIDWEST'S LARGEST PORSCHE AUDI DEALER

CALL VINCE PISHA (312) 297-2880

## *Environmental Decontamination:*

# A Major Approach to Infection Control?

By Larry D. Edwards, M.D./Rockford

Members of hospital infection control committees must often define the amount of emphasis to be placed on environmental "prevention" of infection. At one extreme are environmentalists who have published studies to demonstrate cleansing techniques of air or inanimate surfaces that result in reduced microorganism counts.[1-5] At the other extreme are clinical infectious disease specialists who point out that these studies have never been adequately controlled. The clinicians cite one crucial variable: does reduction in environmental microoganism counts result in reduced patient infection rates?[6-7] Both the environmentalist and clinical specialist usually see the need for microbiological surveillance of medical devices that go into or onto the patient.[8-9]

### Economic Considerations

Surveys were conducted at five hospitals with 200, 300, 350, 450, and 800 beds. The total annual budget expended on antiseptics and disinfectants was determined. Each hospital averaged $4-5000 per annum for each 100 beds. Approximately two-thirds was spent on disinfectants and one-third on antiseptics. This finding prompted a literature review to determine if such an expenditure was necessary.



LARRY D. EDWARDS, M.D., is an internist in Rockford. Doctor Edwards is director of the division of infectious diseases at the Rockford School of Medicine and a consultant for the Winnebago County Health Department. He is a diplomat of both the National Board of Medical Examiners and the American Board of Internal Medicine.

### Literature Review

The literature in this area should be interpreted with caution. It is important to note that testing of disinfectants for eradication of microorganisms should be done with media containing a neutralizing agent or the disinfecting agent must be removed.[10-12]

### "Surface Decontamination"

Walls have been shown to have low colony counts of microorganisms that are not representative of organisms from infected patients. They need to be cleaned with soap and water only when grossly soiled for aesthetic purposes.[13-14]

Several studies have found that multiple disinfectants as well as soap and water have little lasting effect on floor decontamination. Bacterial counts return to baseline levels within one to two hours after cleaning and the effect is similar with disinfectants, soaps, or plain water.[15-20] Although floors are contaminated with many microorganisms, little redispersion occurs even with coagulase positive staphylococci after mechanical production of air currents.[18] Tacky or disinfectant mats have no effect on floor disinfection.[18] Plastic mops can inactivate disinfectants.[21] Wet mops can rapidly build up large numbers of microorganisms and spread them to other surfaces. The most effective way to decontaminate mops is daily laundering and drying, not chemical disinfection.[22]

There are conflicting data on microbiological evaluation of carpeting in hospitals. It is clear, however, that they are more susceptible to contamination than are non-carpeted floors. Any cleansing technique or vacuuming results in in-

creased air counts and is followed by rapid recontamination. Disinfectants are even less reliable on carpeted floors.[23-26]

In summary, daily cleansing of floors with the cheapest available soap and water is as effective a method as any currently available. Mops should be laundered and dried daily. Carpets may be used in non-patient areas but their allergenic and contaminative potential must be counterbalanced against potential reduction in noise pollution. Carpets should be vacuumed and shampooed regularly.

### Air "Decontamination"

Intricacies involved in the spread of airborne infection make it difficult to interpret the efficacy of air decontamination studies. Droplet nuclei, true airbone particles which do not settle out before ventilation (e.g., tubercule bacillus) and dustborne material can both be spread by the airborne route.[27-28] The latter may harbor infectious coagulase positive staphylococci which are large enough to settle out before ventilation removes them. One author has estimated that less than 1% of nosocomial infections are spread by the airborne route whereas others feel it accounts for the majority of such infections.[29-31] The fact that gram negative rods which are spread predominantly by contact or in solutions are the most ubiquitous perpetrators of nosocomial infections today would favor the latter theory.[32] Even organisms that are known to have some airborne spread through dust particles (such as the coagulase positive staphylococci) appear to be spread more frequently by contact.[29] Regardless of the percent of airborne route infections, it is relevant to determine whether or not the air can be effectively decontaminated.

Studies done at the Center for Disease Control in Atlanta, Georgia, have demonstrated the ineffectiveness of room fogging with phenols, quaternary ammonium compounds or iodophors for terminal room disinfection in patient isolation.[33] Cans of disinfectant sprays are still less effective.

Ultraviolet light did not decrease the incidence of wound infections in a study of 15,613 wounds in five university hospitals.[34] It has had some value in reducing acquisition of tuberculosis from known disseminators but most tubercular spread comes from patients not yet recognized or diagnosed.[30,31,35]

A one-year study comparing recirculating ultraviolet air-sterilizing systems on one ward, an air filtration unit on another, and appropriate controls on the two control wards, had negative results. Additionally, germicides were used on surfaces in two wards compared to "dummy" germicides (water) with identical containers on two other wards. Such in-use conditions had no observed effect on staphylococcal surface counts. A 20% reduction in total count was found on both air-filtration wards compared to controls. However, no significant difference was noted in the hospital-acquired infection rate.[36] Whereas laminar air-flow advocates abound, no carefully controlled study monitoring infection rates has been done.[37]

For the case infected with a pathogen known to be vulnerable to airborne spread, the best isolation procedures include: specific, effective antimicrobials in order to reduce the inoculum, single room isolation, closed door with air vented to the outside of the hospital and avoidance of common air duct systems. It is also helpful to teach the patient with a productive cough proper techniques for coughing and sputa disposal and provide a well-fitting mask designed to filter out droplet nuclei (<0.5 micron) when exposed to others. Employees should wear such masks during close contact.[35,38]

### General Environment

Multiple efforts have been expended on the study of hydrotherapy tanks, waste-traps in sinks, surgical masks and gowns, laboratory coats, bedpans, toilets, stethoscopes, audiometer earphones, nursing bags and other disposables as potential vehicles for the spread of infection.[39-53] None of these studies have been correlated with infection rates in patients or personnel. However, they document the fact that sterility is a relative rather than an absolute concept. At best, sterility may be defined as the transient state of the abscence of microorganisms.

### Disinfectants

The term "disinfectant" usually denotes an agent that is applied to inanimate surfaces or objects for the purpose of inhibiting microbial growth.[54,55]

The same reasoning applied to antibiotics by practicing physicians should be applied to any antimicrobial agent, including disinfectants and antiseptics. They have a defined spectrum of activity, a therapeutic/toxic ratio and cost money. All these factors should be weighed when selecting a disinfectant or antiseptic. Proper selection,

concentration and use of these agents has been detailed elsewhere and will not be reviewed here.[55-58]

Hughes has documented the misuse of disinfectants and antiseptics as well as the wasted funds involved. In his study, the greatest waste was analagous to the problems associated with antibiotic use, e.g., use when not indicated through ineffective modes.[59]

The major problems with disinfectants include (a) failure to disinfect and (b) ability to support bacterial growth and become "infectants."[60-62] One study has even suggested single-pack units to reduce contamination and thus the potential for a common source outbreak.[63] A study in 14 hospitals and 140 wards under in-use conditions demonstrated that disinfectants failed to live up to their name. Mops, hard surfaces such as tables and floors, bath tubs, cleaning brushes, nailbrushes, wash bowls, bedpans, urinals, toilet brushes, etc., were contaminated with a variety of organisms although a large variety of "disinfectants" were in use.[64]

The quaternary ammonium compounds are common disinfectants implicated in serious outbreaks of nosocomial infections.[65-71] Inactivation of these compounds by organic material, cotton sponges and corks has been documented.[65-67,72,73] In addition, without such inactivation, these compounds have supported growth of strains of Pseudomonas aeruginosa, Escherichia coli, and spores of Bacillus subtilis and Clostridium sporogenes.[74-77] Allergic contact sensitivity has been demonstrated in the conjuctiva and skin of humans and mice (benzalkonium chloride is often used as a preservative in opthalmic solutions).[78,79] These compounds have not been found superior to any of the other disinfectants. The tinctures of benzalkonium which contain alcohol do show increased activity but are not superior to alcohol alone.[62] It would seem judicious to avoid using all quaternary ammonium compounds because of their poor track record as disinfectants and their "infectant" and allergic potential.

Phenolic compounds have also been shown to support the growth of gram negative rods such as Alcaligenes faecalis.[80]

In summary, disinfectants are often "effective" under artificial laboratory conditions, but not in practical use. Heat sterilization and ethylene oxide sterilization with proper aeration for equipment parts which cannot be heat sterilized are recommended. Glutaraldehyde (properly applied) for some anesthetic machine parts if heat or ethylene oxide cannot be used and 0.25% acetic acid nebulization is a preferable and acceptable means for decontaminating inhalation therapy, anesthetic and other similar medical equipment. Cold sterilization with disinfectants should be avoided when possible, particularly on inanimate surfaces.[57,81-90]

### Antiseptics

The term "antiseptic" usually denotes an agent that is applied to human skin and appendages to inhibit microbial growth.[55]

One author has stated a common aphorism: "There is no doubt that if all personnel washed their hands as often as they should—before and after handling a patient, before and after eating and after using the bathroom—nosocomial infections would be minor problems."[91] There is no doubt that most nosocomial infections occur through the intermediary of hospital personnel's contaminated hands.[92,93]

Hexachlorophene soaps are effective in decreasing the population of gram positive organisms on the skin when used daily for several days.[94] However, hexachlorophene soaps and other antiseptics have been shown to support growth of gram negative bacilli and Candida albicans for variable periods of time.[95] An outbreak in an intensive care unit involving colonization of 14 patients with eight clinical infections and one death was traced to secondary contamination of a 3% hexachlorophene dispenser with Serratia marcescens.[96]

Any type of hand washing (including 3.0% hexachlorophene, liquid saponified coconut oil, 7.5% providone-iodine, 0.75% free iodine, 7.0% ethanol emulsion, Ivory soap bars and tap water with drying on paper towels) is equally effective in ridding the hands of transient microorganisms.[97]

It is common practice for personnel to apply a hand lotion to prevent chafing after frequent hand washing. Unopened bottles of these lotions, however, are contaminated with gram negative rods 70-100% of the time and have produced an epidemic of nosocomial infections involving six patients with Klebsiella pneumoniae serotype 18 bacteremia.[98,99]

In order to decide the best means of delaying contact spread of bacteria, more work is needed to ascertain the efficacy of using inexpensive, nonsterile, disposable gloves between patients. This is particularly pertinent to intensive care units, where contact is frequent with patients predis-

posed to infection. Frequent hand washing with a mild, non-contaminated soap without the use of hand lotions may be a reasonable alternative.

For procedures such as insertion of catheters and lumbar punctures, present data would indicate that cleansing the skin with soap followed by a three minute scrub with 70% isopropyl or ethyl alcohol is the most effective means of reducing total skin bacterial counts.[57] Some prefer to use 0.5% iodine in 70% alcohol but this has the added problem of iodine sensitivity in some individuals. For sensitive mucous membranes, thorough cleansing with soap and water only or providone-iodine is appropriate.[94]

Although some authors suggest otherwise, available data on the infective potential of hair on the head or face is equal to other skin carriers or disseminators of microorganisms like coagulase positive staphylococci. Covering hair in the operating room and frequent shampoos have been recommended.[100-102]

## Conclusion

Epidemiologic surveillance of nosocomial infections through a nurse epidemiologist is the recommended approach to documenting the rate of nosocomial infection. This data may be used to suggest control approaches and determine their effectiveness.[103,104] One author has suggested that many hospitals without an epidemiologic surveillance program may not be able to afford one, and that in this situation environmental surveillance is better than nothing.[105] However, a 300-bed hospital spending $15,000 per year on disinfectants and antiseptics and additional monies on environmental cultures of floors, etc., has the potential for converting the majority of these funds to a budget for a nurse epidemiologist. Medical institutions should give priority to monies for epidemiologic surveillance using a nurse epidemiologist rather than environmental surveillance of inanimate surfaces and air with attendant use of unnecessary disinfectants and antiseptics. ◄

### References

A complete list of references for "Environmental Decontamination: A Major Approach to Infection Control?" may be obtained by writing the *Illinois Medical Journal*, 55 E. Monroe, Suite 3510, Chicago, 60603.


**LOW-COST GROUP INSURANCE ANOTHER ISMS MEMBERSHIP PRIVILEGE**

**THE GROUP DISABILITY PLAN** ● Provides up to $1,732.00 monthly in the event of disability caused by Accident or Sickness. ● Special Guaranteed renewal feature. ● Protect your income and security.

**BUSINESS OVERHEAD EXPENSE PLAN** ● Pays your office overhead expense when disability strikes. ● Premiums are Tax Deductible. ● Pays in Addition to the Disability Plan Benefits.

**THE BASIC MAJOR MEDICAL EXPENSE PLAN** ● In or out of Hospital Benefits up to $25,000.00 per Disability. ● Up to $100.00 Daily Hospital Room and Board maximum. ● Subject to choice of deductible and 80% coinsurance.

**EXCESS MAJOR MEDICAL PLAN** ● Provides up to $250,000 for Medical Expenses. ● Supplements **any** Basic Major Medical Plan and has a $25,000 deductible. ● Low group rates. ● Truly **catastrophic coverage.**

FOR INFORMATION, ASSISTANCE & DETAILS CONTACT:

Administrators:
PARKER, ALESHIRE & COMPANY
ESTABLISHED 1901
Insurance

9933 N. Lawler Avenue
Skokie, Illinois 60076
Phone: 312-679-1000

# Attacking the Cost Crisis

*The ISMS-sponsored Task Force on Cost Effectiveness was created to identify and ameliorate the causes of spiralling health costs in Illinois. Represented on the Task Force are ISMS, Blue Cross/Blue Shield, Illinois Hospital Association, Illinois Clinic Managers Association, Chicago Hospital Council and Chicago Medical Society.*

*The following articles—developed at the request of the Task Force—outline a number of practical suggestions for containing costs. They are intended to focus attention on the issues and stimulate your participation in Task Force efforts. A periodic series of articles to be featured in* IMJ *will illustrate specific suggestions for holding down costs.*

*If you have initiated successful cost-saving measures in your practice, outline them in a short article (500 word maximum) and submit it—along with a personal photograph—for possible publication in* IMJ. *Later this year the Task Force may reprint these articles and others in booklet form to assist in development of individual or area-wide cost containment programs.*

*Please note that views expressed in these articles are those of the author, and are not intended to reflect official positions of any organization represented on the Task Force.*

# Physicians' Viewpoint on Cost Containment

By J. M. Ingalls, M.D./Paris

The causes of the medical cost spiral usually are attributed to factors in four major areas—government interference, societal demands, hospital practices and physician indifference. Compounding the problem is the insurance structure's influence on the demand for medical care.

The physician who ignores his own contribution to the cost problem is shirking his responsibilities. By neglecting to put his own house in order, he is denying himself the opportunity to speak from the position of strength and leadership that is rightfully his. Responsible physician attention is mandatory in several areas, including:

- *Changes in the medical education system.* Student must be schooled in the financial aspects of patient care, and closer supervision of house staff ordering must be instituted.
- *Differentiation between good clinical medicine and excessive defensive practices.* Special attention must be paid to unnecessary testing, excessive consultation and over-utilization of hospital facilities.

The practicing physician must take a hard look at many of medicine's time-honored practices and re-evaluate their usefulness. Many of these no longer are cost-effective in today's economic climate. For example:

- Well baby visits every 30 days may not be necessary. Perhaps less frequent visits can produce the same benefits to parents and child at reduced cost.
- Surgeons should re-evaluate the need for surgery.
- Outpatient surgery should be conducted as often as possible to eliminate costly hospitalization.
- Improved technology should be used in outpatient treatment.
- Earlier discharge of patients should be effected if the patient's ultimate well-being is not jeopardized.
- Copies of his patients' hospital bills should be consulted by a physician to increase awareness of the cost aspects of ordered treatment.

At the same time, the practicing physician must increase his input into the development of health insurance programs. Although the ultimate responsibility for the cost-effectiveness of insurance plans rests with the patient and third-



J. M. INGALLS, M.D., is an Illinois State Medicol Society past president. He is currently choirmon of the ISMS Tosk Force on Cost Effectiveness.

party payor, the role of the physician cannot be ignored.

We must educate the public and media about the cost of medical care, *especially* from our vantage point . . . and especially as related to the effects of government, third-party payors and societal demands. Also, we must work toward a new level of public awareness of responsibility of the individual for his own health and life-habits.

Cost containment cannot and must not mean less adequate medical care. However, for the physician it can and should mean more attention to increased direct *personal* contact with the patient. This will offset a portion of the malpractice threat that hangs over his head. Finally, we must present strong, consistent assurance to the patient, government and third-parties that what we—as trained, concerned physicians—are doing is relevant, timely and proper. And, we must assure them that our actions are in the patient's best interest, as decided by our personal concern—which includes an awareness of the ramifications of delivering health care in today's medical-economic climate.

# *Is One Million Enough, Mr. Secretary?*

By Gerald W. Mungerson, Executive Director,
Illinois Masonic Medical Center/Chicago

The management team at Illinois Masonic Medical Center was weary and angered. We had tired of such terms as "obese" or "profligate" from the current HEW secretary (who has praised the British system as a model of health care efficiency). We set about to prove that, without fanfare or bureaucratic prodding, a significant amount of money is saved by a cost conscious medical center doing its job.

Each medical center department was asked to document how much had been saved in the past year and to describe efforts to economize. The results were staggering! One million dollars—2% of the annual budget—$6.00 per patient day. In any terminology, an impressive amount of money was deleted from the patients' bill. The savings ranged from $650 annually in the Security Department, where locks are now repaired by the Medical Center staff rather than sent out for repair, to a $67,000 savings in the Medical Transcription Department through purchase of new equipment. A sampling of the ways in which IMMC saved money follows:



GERALD W. MUNGERSON is executive director of Illinois Masonic Medical Center in Chicago.

- During periods when the patient census is low, nursing personnel are encouraged to take excused absences without pay. In addition, other nursing personnel are shifted to units requiring more help during these periods. In some cases, entire nursing units were shut down. Such measures account for a savings of approximately $20,000 annually.
- The Environmental Service Department of IMMC uses 219,000 pounds of soiled dust and wet mops annually which it had sent to an outside laundry. IMMC purchased an industrial washing machine and dryers to launder its own mops. Approximate first-year savings: $40,000.
- The Inpatient Business Office instituted a letter service prior to placing accounts with a collection agency. Three letters are sent under a credit bureau name to delinquent accounts at a cost of $1.50 per account. During the first ten months of the program, $25,000 was collected at a cost of $1,300. For this service a collection bureau would have retained $8,400 or a savings to IMMC of $7,100. This will save the institution $10,000 annually.
- IMMC has a working relationship with St. Joseph's Hospital for hearing testing machines. This includes sound field testing for infants under three, hearing and evaluations, and accoustic impedance audiometry. If IMMC were to purchase these machines it would cost about $50,000.

– By switching to 35 watt-miser fluorescent lamps in place of the 40 watt bulbs and using longer life incandescent lighting, our annual costs in light have been reduced by $33,000.

The complete report documents in detail the almost 50 different ways in which IMMC is saving its patients money. Many are small efforts, saving only $500-$5000. But that only seems to prove that no department is too small to make an effort. None of this could or would occur without the interest and cooperation of the medical center's medical staff as evidenced in areas such as the operating room and radiology.

We don't expect the secretary of HEW to be mollified or silenced by this report. But we do hope that he will listen to responsible spokesmen. They can articulate what is being done now and what they will continue to do to contain those costs within their control!

# Cost Containment

Robert W. Seeger/Chicago
Executive Administrator, Field Clinic

Cost containment in a clinic must be a constant effort. Any program must have the total support of every member of the medical group. This aggregate support must reflect the physicians' work habits, consecutive scheduled office hours and appropriate utilization of all examination rooms. A fragmented effort will not generate the anticipated overall economy.

The majority of services rendered in a physician's office or clinic are the patient's financial responsibility. When physicians increase office fees, patient visits usually diminish. Reduced patient visits, of course, cause a decided decrease in anticipated earnings. To forestall fee increases, reduction of patient utilization and diminuation of clinic income a positive cost containment system must be implemented.

As administrator of a multi-specialty group which has been a partnership and a group practice since 1945, I observed that a total cost containment program takes time to evolve. My procedure to reduce overall expenses extends to personnel, purchasing, budget and medical audit review considerations.

## Personnel

A major clinic cost area is non-medical salaries. Personnel review by the clinic manager and/or personnel manager is a high priority factor. Total patient satisfaction is the result of a complete clinic experience. Personnel morale is determined not only by wages, but also the working conditions and communication from both the supervisors and the administrator's office. Termination interviews with departing employees will offer an insight into positive or negative areas in the specific work areas of the clinic. Supervisors are necessary, but unqualified supervisors cause unnecessary turnover.

New employee training is an expense to an organization. Periodic reviews permit the supervisor to evaluate the employee in a formal manner. It is an opportunity for frank communication.

Why pay overtime? Management must review payrolls and department workloads. Overtime is naturally a benefit to the employee, but it decreases the yield to the clinic. Management analysis will determine the proper time to add additional employees, decrease overtime, and improve departmental productivity.

## Purchasing

Medical and office supplies are necessary for daily function. Inventory levels, expense, and delivery schedules are determined to satisfy daily requirements. Periodic price reviews with all vendors generate cost savings. Inventory levels may be adjusted according to current costs. Reduced cost can be realized by an increase in volume ordered. An annual basis for contracted services guarantees fixed prices. Obtaining addi-

ROBERT W. SEEGER is executive administrator of the Field Clinic in Chicago and a member of the Illinois Clinic Managers' Association.



tional bids at renewal time will generate substantial savings.

**Budget**

The principal tool is a budget, which requires quarterly review. The organization should receive formal income and expense reports reflected on a departmental basis. Budget preparation must involve the supervisor of each department. Final budgets and the quarterly review should be discussed with all supervisors. This communication and involvement is an educational tool for them, as well as a means of reducing cost.

**Medical Audit Review**

A physicians' board should review medical records on a bi-monthly basis to evaluate proficiency. This is information in relation to cost containment of patient services.

Self-imposed cost containment in the health field is imperative. Without it, we may once again find governmental control similar to Phases I thru IV earlier in this decade.

# *Cost Containment Ideas*

By Richard C. Shaw, M.D./Chicago
Vice President and Medical Director, Illinois Blue Cross and Blue Shield

What can physicians do to decrease the cost of health care for their patients without jeopardizing quality of care? One alternative is pre-admission testing whenever possible. At least one to three pre-surgical hospital days can be eliminated by obtaining much of the necessary work-up for elective or scheduled surgery on an out-patient basis. This may not always be the most convenient mode, but at current hospital room rates it can save many health care dollars. The same rationale applies to out-patient diagnostic tests for which patients were often hospitalized. Many diagnostic tests frequently done in the hospital can be performed in the physician's office or hospital out-patient department.

An integral part of effective pre-admission testing is proper attention to standing orders for hospital surgical patients. Obviously, savings in pre-admission testing would be lost if tests were duplicated after admission.

Elimination of unnecessary standing orders for hospital patients can be cost effective beyond pre-admission testing. If all aspects of each patient are taken into account at the time of admission, many routine tests might be removed from standing order status. Age and recency of the same tests performed in or out of the hospital can alter the absolute clinical need for certain tests. The same might be true of routine standing orders that apply during the course of a patient's stay. In consideration of sound medical practice and concern for patient finances, physicians and medical staffs could revise standing orders to the benefit of many patients.

Increased use of out-patient surgical facilities is an excellent aid to help health care cost containment. Just as in pre-admission testing, elimination of in-patient hospital room charges can significantly lower the cost of health care for many patients. For some physicians the idea is new. Others find the change from accustomed procedure uncomfortable. However, with only modest effort a conscious decision to consider out-patient surgical facilities can appropriately contribute to decreased health care costs.

The best results in any endeavor come from planning. So it is with patient care. Hospital-level care can be most efficient when quality care is delivered economically. An essential element in least cost is planning to provide for the earliest possible discharge of patients from a hospital to a less sophisticated medical facility or home. Proper care can then be continued at lower cost. Discharge planning assures not only the earliest possible release from the hospital, but also continuity of quality care after discharge. ◄

RICHARD C. SHAW, M.D., is vice president and medical director of Illinois Blue Cross and Blue Shield Corporation.



CME CONFERENCE

# Penetrating Wounds of the Neck and Mediastinum

By G. V. Paniker, M.D. and Thomas G. Baffes, M.D./Chicago

One of the most dangerous lesions that can be sustained in the thorax is a penetrating injury that traverses the mediastinum or an adjacent portion of the neck at the thoracic inlet. A moment's consideration demonstrates that almost every essential structure connecting the cranial portion of the body with the abdomen is closely compacted in this central region. These vital structures are so closely compacted that fatal injury would seem almost inevitable. Yet, when we reviewed our experience with such injuries at the Mount Sinai Hospital Medical Center. we were surprised to find that a substantial number of patients could be successfully managed without immediate thoracotomy surgery, and that mortality and morbidity was maintained at a respectable level. This was particularly gratifying because critical structures (e.g., esophagus, trachea, heart, aortic arch, descending thoracic aorta, spinal cord, vena cavas, vagus nerves, phrenic nerves, etc.) were exposed to potential injury. We present some illustrative cases, and then review a recent statistical survey of the problem as it was encountered during the period 1970-1977.

### First Case History

A 24-year-old black male was shot at close range with a .22 calibre bullet on the right side of the neck, anterior to the sternomastoid muscle, below the thyroid cartilage, while he had his head turned toward the assailant. The anticipated course of the bullet was posteriorly, medially and down toward the left lung. On roentgenogram of the chest, the bullet was visible in lung's left upper lobe region. (Fig. 1A) Hemopneumothorax was present. Subcutaneous emphysema of the neck was noted and a small air leak was found through the entry bullet hole. (Fig. 1B) Under observation, this air leak increased, so a left closed thoracotomy chest tube was inserted, draining 400 cc. of blood into the water seal reservoir almost immediately. The patient's respiratory distress increased. Endotracheal intubation was attempted without success because of severe epiglottic and vocal cord edema.

Tracheostomy was done and the patient was immediately taken to the operating room for wound exploration under general anesthetic. The neck was explored through a longitudinal incision along the right sternomastoid border. The trachea and esophagus were examined and a laceration of the right postero-lateral wall of the trachea was closed with 4-0 Prolene® sutures. Another laceration was noted on the left anterior esophageal wall; it was closed in two layers. Further exploration was hampered by the tracheostomy, but no other cervical organ injuries were noticed. Interposition of strap muscles between the trachea and esophagus could not be done because these muscles had been divided in the course of exploration. A left anterior thoracotomy was undertaken to explore for additional injuries in the thorax. The apex of the left upper lobe was sutured to control bleeding from the bullet wound. Gastrostomy was performed through a small laparotomy incision and a nasogastric Levine® tube left in place.

In the postoperative period, respiratory complications were minimal. The patient was ex-

---

G. V. PANIKER, M.D., is a thorocic and cardiovascular surgeon affiliated with Mount Sinai Hospital in Chicago. Doctor Paniker is a former instructor in surgery from the Chicago Medical School and is currently on the faculty of Rush Medical College.

THOMAS BAFFES, M.D., Esq., is chairman of the department of surgery at Mt. Sinai Hospital and an attending surgeon at several other hospitals. He is also a lecturer at DePaul University School of Law. Dr. Baffes has published numerous articles and is a member of many professional organizations.



**Figure 1A**
**Roentgenogram of chest in Case I showing bullet in left lung.**



**Figure 1B**
**PA view of chest, Case I. Note mediastinal and cervical emphysema.**

tubated on the ninth postoperative day. Gastrografin swallow was done prior to chest tube removal on the seventh postoperative day, and again before oral feedings were started four days later. The patient had initial difficulty swallowing both solids and liquids and aspiration resulted. He was bronchoscoped on three subsequent occasions for evaluation of tracheo-esophageal fistula (which was not found), and for removal of sutures in the tracheal wall. Barium esophagogram was also repeated to ensure that no tracheo-esophageal fistula could be demonstrated. Four months after surgery, the patient was able to eat solids well and had gained some weight. He continued to have slight difficulty swallowing liquids. No specific pharyngeal nerve paralysis could be demonstrated.

### Case Two: Chest Wound

A 20-year-old white male was admitted to another hospital with a gunshot wound in the left chest, entering the sixth intercostal space in the midaxillary line. The anticipated trajectory of the bullet was medially and slightly upwards, ending just on the right side of the mid-sagittal line of the thorax. (Fig. 2A & B) Immediate resuscitation was done at emergency room admission and a left closed thoracotomy tube inserted, draining over 700 cc. blood for the next twelve hours. He was not transfused with blood and his vital signs remained stable. Portable roentgenograms of the chest over the next few days showed progressive but slight enlargement of the cardiac shadow. The closed thoracotomy tube was removed on the fifth post-injury day and he was allowed to ambulate. On ambulation, he experienced exertional dyspnea. Additional roentgenograms were done and strongly raised the possibility of pericardial effusion. (Fig. 3) On the seventh day following injury, patient was transferred to Mt. Sinai Hospital.

The patient was then scheduled for surgery with standby cardiopulmonary bypass. A right anterior thoracotomy was performed. Hemopericardium was noted, and after evaluation of the great vessels and the myocardium, the bullet was located. It was imbedded in dense fibrous tissue between the right main pulmonary artery and the right main stem bronchus very close to the carina. The bullet had obviously not completely penetrated the bronchus, but we could not be sure that it was free of the right main pulmonary artery. The right main pulmonary artery was



Figure 2A
Roentgenogram of chest, Case II showing missile lodged just below the right main stem bronchus, in the midline.




Figure 2B
Laterial view of chest, Case II. Note missile is lodged in the region of the right pulmonary artery.



Figure 3
PA Roentgenogram of chest, Case II, showing enlargement of the cardiac shadow indicating pericardial effusion and suggesting injury to the heart or great vessels.



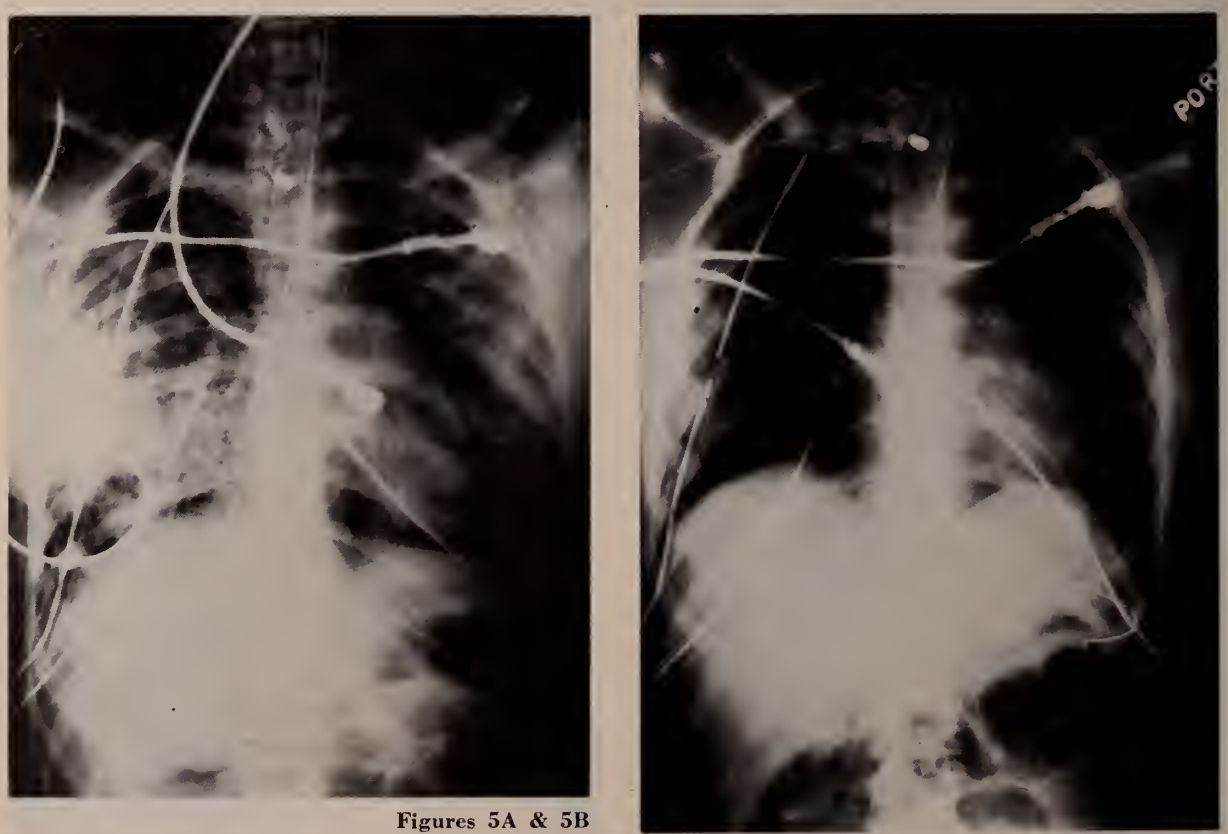
Figure 4
Immediate portable PA chest film, Case III, showing bilateral pneumonic infiltration probably resulting from aspiration. There is also some suggestion of mediastinal emphysema.

cross-clamped proximally and distally, and a longitudinal arteriotomy was done. This showed a 5.0 mm. tear on the posterior wall of the right main pulmonary artery which was sealed off with organized clot. The tear was repaired with 6-0 sutures. On attempting to extract the bullet, it was apparent that its excision would entail some form of bronchial or carinal resection. For this reason, the missile was left *in situ,* in the absence of any local infection. A small piece of Teflon felt was interposed between the tip of the missile and the posterior laceration repair. After restoration of blood flow through the right main pulmonary artery, the thoracotomy was closed. His postoperative course was uneventful. After discharge, he was followed as an outpatient and there were no subsequent untoward complications or symptoms.

**Case Three: Vertebral Involvement**

A 12-year-old black female was shot with a .22 calibre bullet at close range, in the suprasternal notch. (Fig. 4) The direction of the missle was somewhat oblique but it travelled essentially in an antero-posterior direction. She was brought into the emergency room within 30 minutes after injury, in a state of shock and extreme respiratory distress. Immediate resuscitative measures were carried out, including endotracheal intubation, oxygen administration, intravenous blood and fluid administration, etc. Roentgenograms of the chest showed acute pneumonitis, bilateral, secondary to aspiration. Needle aspiration of the pleural cavities demonstrated serous fluid. The bullet was located in the projection of the second thoracic vertebral body, just to the right of the midline.

Exploration of the neck was carried out through a right-sided incision along the anterior border of the sternocleidomastoid and a laceration of the tracheal wall in the midline was closed with 4-0 Tevdec® sutures. Further explora-



**Figures 5A & 5B**

**(A)—Postoperative roentgenogram, Case III, indicating passive congestion of both lungs which required limitation of fluids, diuretics, mechanical ventilation, tracheo-bronchial aspiration and I.V. albumin for therapy. (B)—Chest film 48 hours after therapy, showing substantial clearing of the pulmonary congestion.**



**Figure 6**
**Long-term follow-up chest film, Case III. The patient has no significant residual pulmonary or cardiac problems. The bullet is still lodged in the body of the second thoracic vertebra, but is asymptomatic.**

**Table 1**

July, 1971 - Dec. 1976

| | |
|---|---|
| TOTAL CASES | 109 |
| Stab Wounds | 46 |
| G S W | 63 |
| Neck | 45 |
| Chest | 64 |

**Table 2**

NECK INJURIES

| | | |
|---|---|---|
| Total Cases - 45 | Died | |
| Operated - 28 | 3 | |
| Conservative - 17 | 0 | |
| Organs Involved | | Died |
| Pharynx - 4 | | |
| Trachea - 3 | | |
| Esophagus - 1 | | |
| Carotidartery + Branches - 5 | - | 2 |
| Jugular Vein - 2 | | |
| Spinal Cord - 2 | | 1 |

tion of the neck failed to locate the exit wound, or show injury to other organs in the immediate area. A right antero-lateral thoracotomy was done, through which the intrathoracic trachea was examined. A laceration of the posterior, membranous wall of the trachea was identified and closed with 4-0 Tevdec® sutures. The esophagus was not injured. The bullet could not be easily removed from the vertebral body.

Thoracotomy drainage tubes were placed in both pleural cavities and the chest was closed. Postoperatively, the patient showed signs of pulmonary insufficiency. (Fig. 5A & B) This was treated successfully with fluid limitation, diuretics and 25% albumin intravenously. Mechanical ventilation was maintained for three days through the endotracheal tube. The postoperative course was otherwise uneventful and she was discharged on the twelfth postoperative day. Paresis of the right vocal cord was noted, but was absent at the end of eight weeks following injury. Bronchoscopic evaluation of the trachea using the flexible bronchoscopic found small granulomas at the areas of suture without any significant stenosis. On continued follow-up examination, the patient has done very well. (Fig. 6)

**Discussion**

A five and one-half year retrospective study at Mount Sinai Hospital from July, 1971 through December, 1976, brought several insights.

During this period 109 cases of penetrating injuries involving the neck and mediastinum were reviewed—46 stab wounds and 63 gunshot wounds were included in this series. (Table I) Neck injuries were the main cause for admission in 45 cases and chest injuries in 64 cases. Very minor and superficial traumas and those associated with more major injuries of other areas were excluded from our selection of neck injuries, since the management of these cases would certainly be influenced by the presence of other major trauma. In mediastinal trauma cases, injuries lateral

to the mid clavicular line and those associated with more major injuries to other areas were similarly excluded. The total number of neck injuries reviewed represents only a third of the neck trauma and mediastinal injuries represent about a fourth of all penetrating injuries to the chest admitted to our hospital during this period.

**Demographic Analysis**

Over 35% of patients were in the 15-25 yr. age group, with a male to female ratio of 4:1. Only seven patients were white, probably an actual representation of the population of our neighborhood. No significant seasonal variation was noted in the number of injuries, although 47 cases occurred in the months June-September.

Presence of shock at the time of arrival in the Emergency Room does not always mean injury so serious as to warrant surgery, nor is it an indication of actual blood loss. Of 15 patients who arrived in the Emergency Room in shock with neck trauma, 10 underwent surgery. Of 25 patients with mediastinal injuries, 18 had to undergo surgery (chest tube not included). Although gunshot wounds in the neck area which cross the midline are not always serious injuries, our experience in chest and mediastinal injuries stands to the contrary. During the period of this review, all gunshot wounds crossing the chest midline have brought either serious injury or death.

**Neck Injuries**

Forty-five patients were treated for major neck trauma during this period. (Table II) Twenty-eight patients from this group underwent surgical exploration of the neck, three of whom died. One death was secondary to complications from spinal cord injury and the other two from myocardial infarctions. Both these patients were recovering well from lacerations of common carotid artery with no evidence of neurological defect postoperatively.

No mortality has occurred in the conservatively managed group of patients and no late explorations were necessary. Decision for surgical intervention was usually made after the initial evaluation and resuscitatory measures. The only delay involved completion of necessary work-up (e.g., gastrograffin swallow, cervical spine x-rays in case of gunshot wounds and angiographic studies when indicated). In addition to fluid/blood replacement, urinary output and CVP monitoring are done routinely. In suspected cases of airway injury endotracheal intubation is done immediately. Any delay in doing so would make later intubation extremely difficult due to edema or shifting of the glottis and vocal cords.

Primary repair of the airway injuries was usually done without tracheostomy which interferes with adequate exploration and mobilization of structures in the neck. Most neck explorations utilized an oblique incision along the anterior border of sternomastoid. This incision seems adequate in exploration of structures below the level of larynx, bilaterally. Organs involved in neck trauma were pharynx 4, trachea 3, esophagus 1, carotid artery + branches 5, jugular vein 2, spinal cord 2.

Carotid injuries involved common carotid vessel in two cases and external carotid artery or its branches in three cases.

**Chest**

A total of 64 cases were received. (Table IIIA

Table 3A

| CHEST | | |
|---|---|---|
| Total Cases | - | 64 |
| Operated | | Died |
| 25 | | 6 |
| Conservative | | Died |
| 39 | | 0 |

Table 3B

| Organs Injuried | | Died |
|---|---|---|
| Cava, Innominate | 4 | 0 |
| Aorta + Great Vessels | 4 | 3 |
| Esophagus | 1 | 0 |
| Heart | | |
| Atrium | 5 | 2 |
| Ventricle | 4 | 1 |

& B) After immediate resuscitatory measures and investigations, 39 of these patients were treated conservatively. Chest tubes were inserted in the presence of pneumothorax and hemothorax. We have not treated hemothorax with needle aspiration. Angiographic studies were done in certain cases. This group includes two cases of shotgun blast where pellets were found within the myocardium. No mortality occurred in this group and late operations were necessary only in two cases for clotted hemothorax and empyema decortication. This is a significantly higher percentage of conservatively treated patients than other institutions report.

Twenty-five patients with mediastinal trauma underwent surgery. There were six deaths in this group: three cases of injury to aorta and its branches, two of the atrium and one of the right ventricle.

Patients who underwent surgery had the following major injuries: cava and innominate vein: four, aorta and branches: four, esophagus: one, atria: five and ventricle: four. Two injuries of heart with large lacerations required thoracotomy and digital control of bleeding in the emergency room with satisfactory recovery later. Pericardiocentesis for signs and symptoms of tamponade was done in three cases only as an immediate measure; these patients were taken to the operating room as soon as possible. Repeated pericardiocentesis was not instituted as a treatment for tamponade, although an absence of active bleeding from the heart at surgery is not unusual.

Patients with serious injuries to the heart, aorta or its branches can present with stable vital signs or become stable after immediate resuscitatory measures. These show no active bleeding after initial blood drainage, which status is very misleading. Four of 13 patients similarly injured started massive hemorrhage in the course of other investigations and despite immediate surgery only one patient with injury to the left common carotid artery could be saved.

Coronary artery lacerations was primarily repaired in one case, and subsequent angiogram showed successful restoration of distal flow. However, in another case where the arteries did not appear to be injured, and angiographically are patent, a moderate-sized aneurysm of the left ventricle at its apex has resulted. Esophageal injuries are rare in our series; these were involved only once in the cervical and once in the intra-thoracic segments.

Finally, when the issue of operative treatment vs. observation arises, the judgment exercised at that point is critical to the survival of the patient. The present trend to explore the patient in doubtful cases will probably save more lives than expectant therapy.[1-4] Some patients in our series have been spared thoracotomy or neck exploration. It is clear, however, that this is acceptable only when the trauma team is readily able and willing to perform immediate surgery, whenever warranted. ◄

### References


1. Asfaw, I., Thoms, N. W. and Arbulu, A.: "Interventricular Septal Defects from Penetrating Injuries of the Heart," *J. Thor. & Cardiovasc. Surg.* 69:450-457, 1975.
2. Hallen, A., Hansson, H. E. and Nordlund, S.: "Thoracic Injuries: A Survey of 765 Patients Treated at the University Hospital, Uppsala, During the Years 1959-1969," *Scand. J. Thor. Cardiovasc. Surg.* 8:34-45, 1974.
3. Smith, R. F., Elliott, J. P., Hageman, J. H., Szilagyi, D. E. and Xavier, A. O.: "Acute Penetrating Arterial Injuries of the Neck and Limbs," *AMA Arch. Surg.* 109:198-205, 1974.
4. Steicher, F. M., Dargan, E. L., Efron, G., Pearlman, D. M. and Weil, P. H.: "A Graded Approach to the Management of Penetrating Wounds of the Heart," *AMA Arch. Surg.* 103:574-580, 1971.



**Physicians,**

**consider a practice in South Carolina** * low malpractice insurance rates, * the opportunity to join a group or partner or establish a new practice in a rural or urban area, * continuing medical education through a system of Area Health Education Centers, as well as two medical schools, * lower taxes, * lower cost of living, * access to both mountains and beaches, and * a mild climate

For information about specific practice opportunities in South Carolina, contact:

**rural health delivery project**

Post Office Box 11188
Columbia, South Carolina 29211
(803) 779-7264

# Physician Recruitment Program

*In an effort to reduce the number of towns in Illinois needing physicians, the Physician Recruitment Program and the Doctor's Job Fair, are publishing synopses in the Journal.*

*Physicians who are seeking a place to practice or who know of any out-of-state physicians seeking an Illinois residence are asked to notify the Program.*

*Any areas wishing to be listed should contact: Mrs. E. Duffy, Physician Recruitment Program, ISMS, 55 E. Monroe, Suite 3310, Chicago, 60603.*

**BRAIDWOOD:** Physician for family practice, 20 miles south of Joliet—60 miles south of Chicago. No other doctor in town of 5,000. Next door to pharmacy. Clinic provided, substantial guaranteed income for 17 hours per week. One year contract. Contact: Ron Radley, Box 795, Braidwood 60408. (815) 458-2224 or (815) 634-4900. (6)

**CANTON:** Coleman Clinic, Ltd. Population 15,000; drawing area 60,000. Twelve physicians; multi-specialty clinic. Planning expansion program. Progressive city and clinic offering outstanding opportunity to primary care physician. Guaranteed salary and excellent benefits. Contact: H. E. Crouch, 175 S. Main St., Canton, 61520. (309) 647-0201. (6)

**CASEY:** Family physician. Practice quality rural medicine having advantage of group, but independence of solo practice. New complete facilities. Financial assistance available. This is the area to work, live, and enjoy families. Superb congenial doctors & colleagues to share your work. Before you decide, come see our operation. Contact: B. F. Vondracek, Casey Medical Center, Casey, 62420. (217) 932-4061. (6)

**CHADWICK:** Rural community in picturesque Northwestern Illinois, 125 miles west of Chicago. Need for a family physician in a solo practice or possible clinical association. Office space available. Contact: Harold Frank, 411 First St., Chadwick, 61014, (815) 684-5154 or 684-5147, Allen Smith, Rural Route, Chadwick, 61014, (815) 684-5200 or 684-5152. (6)

**CHICAGO:** General Surgeon—group located in 300-bed hospital in Chicago has an immediate opening for a general surgeon. Excellent benefits and salary. Reply to Box JP, c/o Physician Recruitment Program, 55 E. Monroe, Chicago, IL. 60603. (4)

**CHICAGO:** Dr. Charles Chadbourn is looking for a doctor to take over practice immediately. Practice consists of obesity, industrial, some private and public aid patients. 7948 S. Western Ave. Call Marilyn at 436-2552 for appointment. (5)

**DeKALB:** Northern Illinois University. Need internist and chief of clinical medicine, psychiatrist and head of mental health, and primary care physicians. Competitive salaries, fringes, 9- or 12-months annual contract, good facilities, 21,200 students, near metropolitan Chicago. Contact L. W. Akers, M.D., University Health Service, NIU, DeKalb, Ill. 60115. AA/EOE Employer. (5)

**DOUGLAS COUNTY:** Population 20,000. General internist needed to serve Tuscola and surrounding area. Family practitioners needed in Villa Grove and Arcola. Twenty-five miles from Champaign and University of Illinois. 58 bed general acute hospital in Tuscola. Contact: Norm Rentz, Administrator, Jarman Memorial Hospital, 704 N. Main St., Tuscola 61953, (217) 253-3361. (6)

**FAIRFIELD:** Population 6,000. Rural area with a service population of 25,000. Seventy miles from Evansville, Indiana. Opening in medical clinic for obstetrician-gynecologist, family practitioner, or internist interested in doing family practice. Financial assistance available. Contact: Dr. Arthur Marks or Dr. Sigmund Konarski, 101 E. Center Street, Fairfield, 62837. Telephone: (618) 842-2187. (6)

**GALESBURG:** Excellent opportunities in ENT, Family Practice, Internal Medicine, Ob-Gyn. West-central Illinois community of 40,000, manufacturing & agricultural center. Home of Knox College. Outstanding educational, recreational, and cultural environment. Financial incentives and new medical office building available. Contact: Marshal G. Maggard, President, Galesburg Cottage Hospital, Galesburg, 61401. (309) 343-8131. (6)

**ILLINOIS:** The Illinois Department of Mental Health and Developmental Disabilities has opportunities in all areas of the state for psychiatrists and primary care physicians. M.D.'s and D.O.'s with Illinois licenses will be considered. Competitive salaries commensurate with training and experience; attractive fringe benefits. Contact: John T. Nelson, M.D., Coordinator of Medical Affairs, 750 South State Street, Elgin, 60120. (312) 742-1040, x321. (6)

**JACKSONVILLE:** Opportunities for family practice, internal medicine, ENT, orthopedic surgery, emergency room. Progressive 250 bed hospital, 40 member medical staff. Prosperous community with service area of 60,000, two colleges, excellent schools, 30 miles from medical school. Financial assistance, office facilities available. Contact: Bernie Gregory, Passavant Hospital, Jacksonville 62650. (217) 245-9541. (6)

**JOLIET:** Illinois Community Needs Family Doctor. We have a new pharmacy and a clinic waiting for you. No MDs in this city of 5,000—with 15,000 population base. In-house X-ray facilities. Sixty miles south of Chicago off I-55; 20 miles southwest of Joliet. Six hospitals within 20 minutes and full service pharmacy next door. Negotiable guarantee. Ron Radley, 815-458-2224 or 634-4900. (3)

**LIBERTYVILLE:** Family practice physician, general practitioner, or internist to join outpatient clinic in rapidly growing area near lakes, shopping centers, recreation areas, and easy access to Chicago theaters, museums and cultural events. Clinic consists of full auxiliary facilities, special procedure rooms and future outpatient surgical center. For information contact: Family Medical Center, Rt. 1, Box 351, Libertyville 60048, (312) 362-9097. (6)

**MUNSTER:** Industrial and Emergency Room physician needed for large midwest multispecialty clinic. Trauma oriented physician only need apply. Competitive first year salary with opportunity for early equal Partnership in 60 man group. All fringes clinic paid—most liberal vacation and PG allowance. No investment required. Send CV to: Thomas R. Hofferth, Hammond Clinic, 7905 Calumet Ave., Munster, IN 46321. (219) 836-5800 (5)

**PEORIA:** Emergency physician—Unique opportunity to start on the ground floor with fee-for-service group in 550-bed medical center seeing 27,000 ER visits. Need career-minded physician for three 16-hour shifts per week with four weeks paid vacation. Compensation 57K with excellent corporate benefits plus incentive compensation. Flexible scheduling to allow individual pursuits in university town of 250,000 in Central Illinois. Contact: Hospital Emergency Physicians S.C., 221 Northeast Glen Oak, Peoria, 61636; phone 309-672-4974. (8)

**PITTSFIELD:** Family practitioners and surgeons interested in locating in rural community area needed. Population 4100; area 18,000. Excellent opportunity for some one wanting to practice in a rural community. Located between Jacksonville, Illinois and Quincy, Illinois on Highways 54 and 36. Contact Mr. Gary Deer, 217-285-2113. (5)

**PRINCETON:** Family physician & internist—population 10,000, lovely community with excellent school and recreational facilities. Excellent hospital facility built in early 1970's. New office building attached to hospital will be completed in Spring of 1978. Specialties of internal medicine, OB, orthopedics, pediatrics, surgery, and urology available to complement the family physician. Contact: Harold L. Autrey, 530 Park Avenue East, Princeton 61356. (815) 875-2811. (6)

**SPRINGFIELD:** Family practitioners — Springfield Community Hospital is looking for you to begin private practice in our new multi-specialty Community Medical Plaza. We offer an attractive package to help you get started. If interested, contact: W. H. Fields, Springfield Community Hospital, 5230 S. 6th St., Springfield, 62703. (217) 529-7151. (6)


**Professionals are talking about . . .**




**CLOVER LEAF TOWERS OFFICE PLAZA**

**Ideally located & suited for professionals.**

10 MINUTES TO I-90 • 30 MINUTES TO CHICAGO

**NEW 3 STORY • ALL ELECTRIC • WITH ELEVATOR**

- Heating & Air-Conditioning Included
- Carpeting — Your Color Choice
- More Than Ample Parking
- Fine Restaurant Located in Building
- Ideal For Medical, Dental Offices
- Entire Floor 10,000 Sq. Ft. — Will Divide
- Tinted Glass — FM Music
- Public & Private Restrooms
- 2 Year Lease — No Increase
- Solid Oak Doors — Vinyl Base
- Individually Controlled Thermostat
- Immediate Occupancy — Brokers Invited

**CLOVER-LEAF REALTY**

**201 E. Army Trail (1½ Miles West of Rte. 53)**
**Bloomingdale, Ill.**
**PHONE 893-1000**




## *Shattering the Preconceptions . . .*

# US-FMG's are not so bad

By Linda L. Hughey, M.D./Wilmette

*This is a monthly column which welcomes contributions, comments, and questions from interested readers. Address all correspondence to Dr. Linda Hughey, c/o the Illinois Medical Journal, 55 E. Monroe, Chicago, Ill. 60603.*

A funny thing happened while interviewing prospective house officers. Several of my interviewees were Americans who had attended medical school abroad (US-FMG's). I regret to say that I had several preconceptions about students who traveled abroad to study after losing the domestic admissions game. These commonly held but unspoken assumptions were that US-FMG's (1) were less qualified candidates to begin with, (2) received inferior training and (3) as a result would be less qualified to assume an American residency. It was a happy surprise to find that these common notions were often untrue. Indeed, the US-FMG's were as a rule more dedicated, more mature, and had more interesting backgrounds than their American-trained counterparts.

The proper qualifications for admission to an American medical school are a chancy mixture of being of the right color, sex, background, and economic backing with a pinch of grades and test scores thrown in. Most admissions counselors freely admit that the bulk of applicants have adequate qualifications. The edge that makes a candidate successful rather than just adequate may be that he fills a quota, knows someone, or spent his undergraduate days in the library at the expense of all else. But do any of those relate to becoming a good doctor? A high grade-point average earned at the expense of human relationships can handicap the student who, when thrust into the clinics, discovers that his patients are human beings, not books. In short, medical school admission is like a giant roulette game in which the winning numbers are unpredictable & the nice guys often finish last.

The quality of training offered in foreign schools varies from excellent to poor, and no one is more acutely sensitive to shortcomings in their training than are US-FMG's. Many American students, assured of a continuing berth in their training, coast through school with moderate amounts of work. In contrast, US-FMG's apply themselves to the basic medical texts with great fervor, inspired by the knowledge that they must excell to regain entry into the American medical training system. Differences in language and educational structure unquestionably burden US-FMGs, but with hard work, determination, and the benefit of some clinical rotations in the U.S., many US-FMG's do come out extremely well qualified.

Some benefits accrue from training abroad as well. Learning to succeed as a stranger in a foreign land can give much self-assurance and maturity, as well as empathy for patients suddenly thrust into a strange hospital setting. Learning to adapt to and accept another culture can prepare a physician to care for and work with people from differing backgrounds. And learning to deal with a language barrier as an outsider may make him more able to deal with the language barriers which commonly arise between physician and patient. These challenges require courage and dedication. The US-FMG shows a desire to become a doctor as well as the ability to pursue his goal against staggering odds.

The House and the Senate have debated hotly in recent months as to whether federal capitation grants should be tied to medical schools' acceptance of foreign transfer quotas. Understandably, many schools have protested this idea vigorously as an infringement of their academic rights. Little can be gained from *forcing* medical schools to accept a quota of transfers, and I applaud the successful efforts of protest by the medical schools which resulted in Senate defeat of this measure. However, medical schools and residency programs alike should recognize that US-FMG's represent a valuable resource. American medical education can benefit from voluntarily retracking US-FMG's into the system via COTRANS and the Fifth Pathway and by giving them serious consideration as residency candidates.

US-FMG's, you have shown courage and determination in your decision to pursue medical studies abroad. You have shown maturity and adaptability in coping with a strange culture. You may have had to learn to teach yourself medicine as well. You have worked hard and demonstrated dedication and perserverence which will be a credit to American medicine. Welcome home.



# Simple drops of water help make COLACE® the most widely use stool softener.

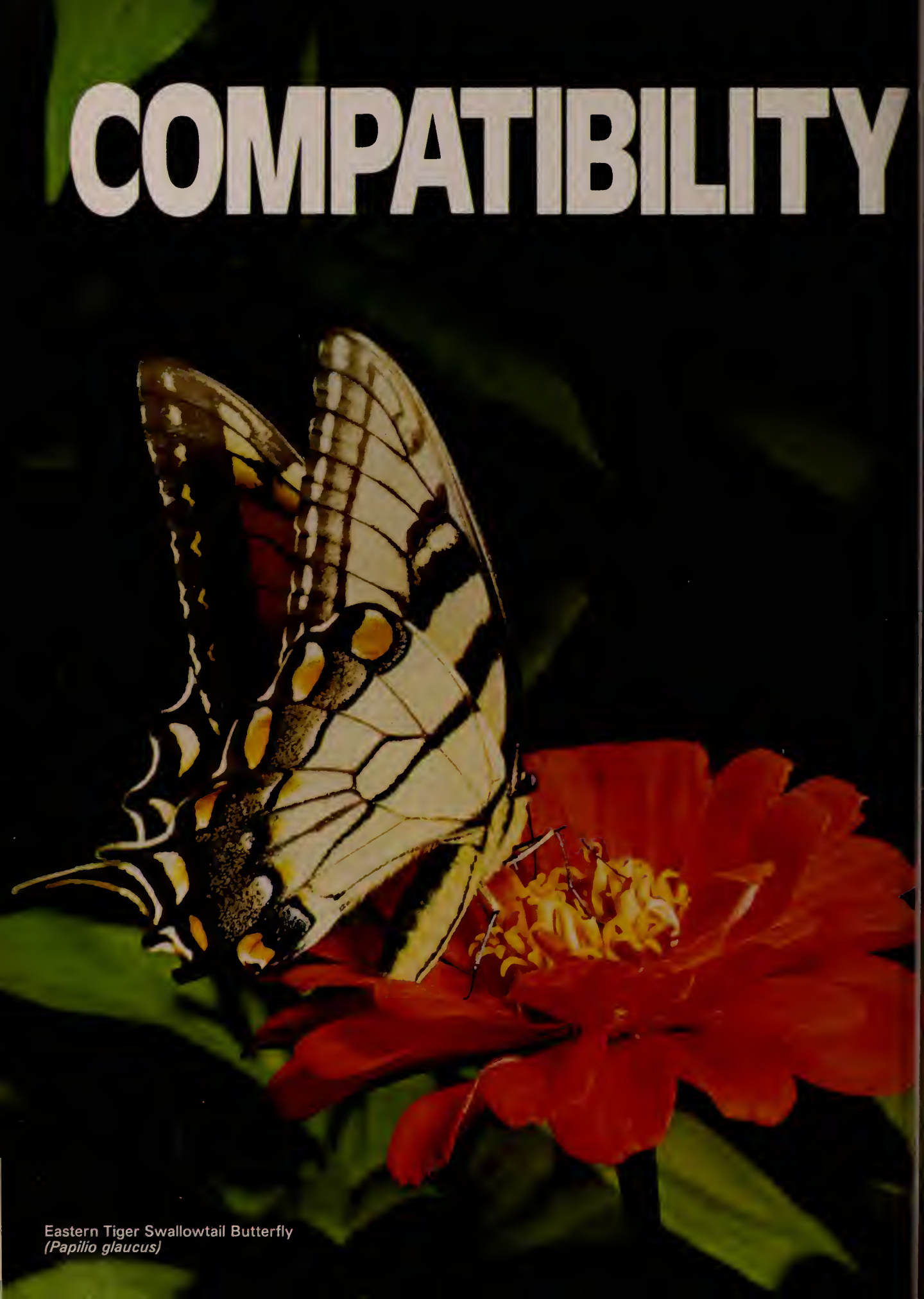
**COLACE®**
dioctyl sodium sulfosuccinate

COLACE works by stool-softening action alone, free from laxative stimulation. Simply by letting natural intestinal water permeate stoo COLACE helps to eliminate the hard, dry stools common to constipat

COLACE works to prevent pain and straining at stool with minimum chance of griping or cramps, particularly in patients with delicate anorectal disorders. COLACE is safe and non-habit forming in short long-term therapy. COLACE—the simple water way to ease constipa from infancy to old age. Capsules, syrup or liquid.

Mead Johnson PHARMACEUTICAL DIVISION

# COMPATIBILITY



Eastern Tiger Swallowtail Butterfly
*(Papilio glaucus)*

# Does it influence your choice of a peripheral/cerebral vasodilator*?

## Vasodilan–compatible with coexisting diseases (e.g., glaucoma, diabetes)

Vasodilan has not been reported to affect the course of coexisting disease; it has not been reported to affect blood sugar levels or to raise intraocular pressure.

## Vasodilan–compatible with concomitant therapy

Vasodilan has not been reported to affect the treatment of coexisting disease; it is compatible with such drugs as hypoglycemics and miotics.

## Vasodilan–compatible with your total regimen for vascular insufficiency

Vasodilan can be a valuable adjunct in planning a total therapeutic program for vascular insufficiency.

*Indications: Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows:
Possibly Effective:
1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.
Final classification of the less-than-effective indications requires further investigation.

**Composition:** Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg. Vasodilan injection, isoxsuprine HCl, 5 mg., per ml.

**Dosage and Administration:** Oral: 10 to 20 mg., three or four times daily. Intramuscular: 5 to 10 mg.(1 or 2 ml.) two or three times daily. Intramuscular administration may be used initially in severe or acute conditions.

**Contraindications and Cautions:** There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

Parenteral administration is not recommended in the presence of hypotension or tachycardia.

Intravenous administration should not be given because of increased likelihood of side effects.

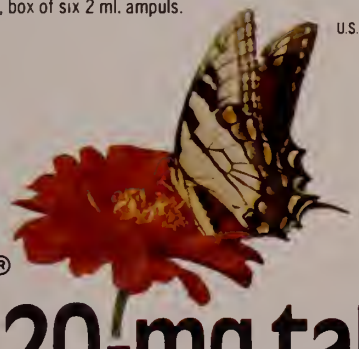
**Adverse Reactions:** On rare occasions oral administration of the drug has been associated in time with the occurrence of hypotension, tachycardia, nausea, vomiting, dizziness, abdominal distress, and severe rash. If rash appears the drug should be discontinued.

Although available evidence suggests a temporal association of these reactions with isoxsuprine, a causal relationship can be neither confirmed nor refuted.

Administration of single dose of 10 mg. intramuscularly may result in hypotension and tachycardia. These symptoms are more pronounced in higher doses. For these reasons single intramuscular doses exceeding 10 mg. are not recommended. Repeated administration of 5 to 10 mg. intramuscularly at suitable intervals may be employed.

**Supplied:** Tablets, 10 mg., bottles of 100, 1000, 5000 and Unit Dose; Tablets, 20 mg., bottles of 100, 500, 1000, 5000 and Unit Dose; Injection, 10 mg. per 2 ml. ampul, box of six 2 ml. ampuls.

U.S. Pat. No. 3,056,836



# VASODILAN® 20-mg tablets

## (ISOXSUPRINE HCl)

**20 mg q.i.d. recommended dosage**

Mead Johnson
PHARMACEUTICAL DIVISION

©1978 MEAD JOHNSON & COMPANY • EVANSVILLE, INDIANA 47721 U.S.A. MJL 7-4237R

# This asthmatic isn't worried about his next breath...



## he's active he's effectively maintained on

# QUIBRON®

Each capsule or tablespoon (15 ml) elixir contains theophylline (anhydrous) 150 mg and glyceryl guaiacolate (guaifenesin) 90 mg. Elixir: alcohol 15%

- high theophylline for effective around-the-clock therapy
- 100% free theophylline
- individualized theophylline dosage schedule

**Indications:** For the symptomatic treatment of bronchospastic conditions such as bronchial asthma, asthmatic bronchitis, chronic bronchitis, and pulmonary emphysema.

**Dosage:** Initial: Adults: 1-2 capsules or 1-2 tablespoonfuls elixir every 6-8 hours, children 8-12: 1 tablespoonful or one capsule every 6-8 hours and children under 8: 3 to 5 mg theophylline/kg body weight every 6-8 hours. Theophylline dosage may be cautiously increased to 2000 mg/24 hr in adults or 7 mg/kg in children; monitoring of serum theophylline levels at higher dosages is recommended.

**Precautions:** Do not administer more frequently than every 6 hours, or within 12 hours after rectal dose of any preparation containing theophylline or aminophylline. Do not give other xanthine derivatives concurrently. Use in case of pregnancy only when clearly needed.

**Adverse Reactions:** Theophylline may exert some stimulating effect on the central nervous system. Its administration may cause local irritation of the gastric mucosa, with possible gastric discomfort, nausea and vomiting. The frequency of adverse reactions is related to the serum theophylline level and are not usually a problem at serum theophylline levels below 20μg/ml.

**How Supplied:** Capsules in bottles of 100 and 1000 and unit-dose packs of 100; Elixir in bottles of 1 pint and 1 gallon.

Mead Johnson

PHARMACEUTICAL DIVISION

© 1978 Mead Johnson & Company • Evansville, Indiana 47721 U.S.A. MJL 6-4220R

report
Illinois Society
American Association of Medical Assistants

# Communication in the Practitioner's Office

The American Association of Medical Assistants, Inc., Illinois Society, and the Chicago Medical Society, will present Gordon H. Deckert, M.D., professor and chairman of the department of psychiatry and behavioral sciences at the University of Oklahoma Health Sciences Center, in a one day seminar for physicians and medical assistants.

The eighth annual workshop is scheduled for Sunday, March 12, 1978, at the Conrad Hilton Hotel in Chicago from 8:00 a.m. to 4:45 p.m. It will mark the beginning of the 1978 Midwest Clinical Conference. Medical assistants will earn CEU credits and physicians will receive Category 1 CME credit for attending the workshop.

This is a communications workshop, designed specifically for physicians and their medical assistants to promote continuity of patient care by enhancing communication skills between doctor and patient, staff and patient, and doctor and staff.

Gordon Deckert, M.D., is well known in Chicago. He is a graduate of Northwestern University Medical School and has returned on several occasions to conduct workshops for health care professionals. This February, Doctor Deckert was honored with a Distinguished Alumni Professor's Award from his alma mater. He has received ten other such awards for teaching excellence. Doctor Deckert's scholarly interests extend to the fields of psychophysiology, emotions, psychosomatic medicine and medical education. He is nationally known for his workshops, which include dramatic, animated presentations, audiovisual aids and audience participation techniques.

Additional program information may be obtained by calling Ms. Linda D. Katek at 312/642-4545. Advance registration will close with those forms postmarked by March 1, 1978. The advance registration fee is $6.50, ($3.50 for students). Registration at the door will cost $8.50, ($5.50 for students). Physicians registered with CMS for the Midwest Clinical Conference are entitled to attend the workshop without an additional fee.

Please return the registration form below to Ms. Jeanne Irelan, CMA-C, 939 N. Seeley, Park Ridge, IL 60068. The check or money order to accompany the form should be payable to: AAMA, Illinois Society, Midwest Clinical Conference. No refunds will be granted after March 2, 1978.

---

**Communication in the Practitioner's Office**

**Sunday, March 12, 1978** **8:00 a.m.-4:45 p.m.**

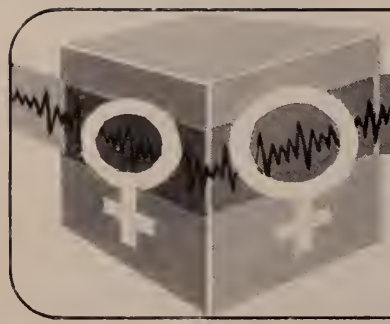
Name:_____ Address:_____

Position:_____ AAMA Member?:_____

Employer:_____ Work phone:_____

Physicians accompanying you to workshop:_____

_____



# *pulse...* of the ISMS auxiliary

Mrs. Eugene Vickery, Editor



***KEY LINES:***

By Betty Szewczyk, President, ISMSA

## *Spring Harvest*

"Getting it all together" seems to be the "in" thing to do and at this particular point in Auxiliary, it is the necessary move. It's time to think about the annual meeting which will be held at the Palmer House in April. The auxiliary sessions are scheduled to begin on Monday morning, April 3 and continue through Wednesday, April 5.

In addition to the unavoidable routine business of an annual meeting, we shall be stimulated by reports from every county in the state. Each president is invited to give a two minute "highlight" report when she will be in the "spotlight" on Tuesday morning, April 4. This should not, and will not, be the same detailed report printed in the Convention Handbook and distributed to each delegate.

Report Time is the "Day of Reckoning"—it's D-Day, when we hear how effective our programs have been during the year. We then find out what kind of bridges we have built and what communication we have established. Have we reached our own members—have they, in turn, reached the community?

Have we carried forth our theme "Teach the Children" with fullest participation in the immunization program? Were most schools in Illinois visited by auxilians with brush and pail in hand to paint Immunization Hopscotch on the playgrounds? Did we do our part to familiarize students with words like diphtheria, rubella, measles, mumps and polio? Report time will tell.

Have we followed through with "CPR" for

Highschoolers, another pet project for this year? Following is a quote from Reuter News Service:

"Heart specialists want to put a new course into grade schools: How to save people stricken by heart attacks. A few schools teach youngsters cardiopulmonary resuscitation, a simple but effective first-aid technique. Now there are hopes of putting such training in most, if not all, schools, perhaps beginning at the seventh grade, said Dr. Stephen W. Carveth of Lincoln, Nebraska.

"The youngsters would become part of a potential army of 40 to 50 million Americans who would know what to do besides call for a doctor or an ambulance," Carveth said.

"Aid must be prompt; the brain begins to die within five or six minutes if blood flow is halted.

"There's good evidence that up to 200,000 lives could be saved each year if only one out of five people knew what to do before professional help arrives," he said.

Report time will tell if Illinois medical auxilians have done their part to recruit this kind of an army.

Have we emphasized the importance of TV in our lives and those of our children. Have we stressed the fact that TV is a salesperson that we pay to come into our homes and intervene in the family unit? We must help set up guidelines for families to turn TV into a learning experience—to become selective and analytical.

Nutrition information, child and drug abuse awareness, parent effectiveness training, babysitter training, safety . . . have we filled the needs of our communities?

We must not fail to include in our accounting of the year's accomplishments the importance of membership, legislation, Benevolence and AMAERF gains. The many facets of auxiliary offer a challenge for all.

**Notes on a Special Person**

Helping us "put it all together" is Jane Swanson, ISMSA Executive Secretary for the past seven years. The ISMS has made it possible for her to be our "Girl Friday" almost every day.

Jane has been highly regarded at ISMS since 1946, when she and Dr. Harold M. Camp established the ISMS Placement Service that accommodated physicians returning from service who were seeking new communities. Jane kept this service functioning until she changed to a part-time status in 1962.

In addition to her Placement Service duties, Jane handled correspondence for the Fifty-Year Club, supervised the headquarters staff stenographic pool and served as membership secretary. She received her B.A. degree from Monmouth College in 1936 and joined the ISMS staff in 1942.



The Auxiliary has been blessed with her expertise about medical society matters and auxiliary participation and she has been largely responsible for the efficiency and professionalism of the operation. Her knowledge of members and functions is titanic. Her cheerful disposition and eager cooperation are a delight.

The Auxiliary office was recently moved to the National Bank of Monmouth Building, 104 E. Broadway, Suite 5, Monmouth, Illinois 61462. Any questions or comments about medical auxiliary will be handled by Jane in her usual friendly and efficient manner. Telephone 309-734-2991. If Jane doesn't know the answer, she'll "get it all together."

# ISMS Guide to Continuing Medical Education

Compiled for Illinois physicians by the
ILLINOIS COUNCIL ON CONTINUING MEDICAL EDUCATION
55 E. Monroe St., Suite 3510 • Chicago, IL 60603 • (312) 236-6110

*Items for this Calendar must be received 90 days prior to the event. Those received earlier may appear in up to three monthly issues.*

*WARNING! Items for this Calendar come from many sources, often far in advance of the publication date. Sometimes, cancellations or changes in date, place or time occur too late to be corrected before publication. You are urged to contact the sponsoring organization to confirm information given below.*

## MARCH

### *Anesthesiology*

**BASIC EKG & EKG FOR ANESTHESIOLOGISTS**
**For:** Anesthesiologists. March 27, 1978, Cook County Graduate School of Medicine, 707 South Wood St., Chicago, IL. **Speaker:** Alon P. Winnie, M.D. **Hrs. of Instr.:** 35. **CME Credit:** AMA Category 1. **Fee:** $200.00. **Reg. Limit:** 50. **Sponsor:** Cook County Graduate School of Medicine. **Contact:** Robert J. Baker, M.D., Dean. **Telephone:** (312) 733-2800.

### *Family Medicine*

**BASIC INTERNAL MEDICINE**
**For:** General Practitioners and Internists. March 6, 1978, Cook County Graduate School of Medicine, 707 South Wood St., Chicago, IL. **Speaker:** Sheldon S. Waldstein, M.D. **Hrs. of Instr.:** 40. **CME Credit:** AMA Category 1. **Fee:** $200.00. **Reg. Limit:** 100. **Sponsor:** Cook County Graduate School of Medicine. **Contact:** Robert J. Baker, M.D., Dean. **Telephone:** (312) 733-2800.

### *General Medicine*

**URINARY TRACT INFECTIONS**
**For:** All Physicians. Lecture, March 7, 1978, 5:00 PM, Henrotin Hospital Board Room, Chicago, IL. **Speaker:** Louise Riff, M.D., Associate Professor of Medicine, Univ. of Illinois College of Medicine, ALSM. **Hrs. of Instr.:** 1. **CME Credit:** AMA Category 1. **Sponsor:** Schering Corporation. **Contact:** William N. Werner, M.D., Associate Director of Medical Education. **Telephone:** (312) 440-7755.

### *Gynecology*

**DIAGNOSIS & MANAGEMENT OF PROBLEMS IN GYNECOLOGY**
**For:** General Practitioners. March 6, 1978, Cook County Graduate School of Medicine, 707 South Wood St., Chicago, IL. **Speaker:** John G. Masterson, M.D. **Hrs. of Instr.:** 38. **CME Credit:** AMA Category 1. **Fee:** $200.00. **Reg. Limit:** 100. **Sponsor:** Cook County Graduate School of Medicine. **Contact:** Robert J. Baker, M.D., Dean. **Telephone:** (312) 733-2800.

### *Neurology*

**NEUROLOGY, PART I, BASIC**
**For:** Neurologists and Psychiatrists. March 6, 1978, Cook County Graduate School of Medicine, 707 South Wood Street, Chicago, IL. **Speaker:** Catherine Haberland, M.D. **Hrs. of Instr.:** 44. **CME Credit:** AMA Category 1. **Fee:** $225.00. **Reg. Limit:** 150. **Sponsor:** Cook County Graduate School of Medicine. **Contact:** Robert J. Baker, M.D., Dean. **Telephone:** (312) 733-2800.

### *Oncology*

**NUTRITIONAL ASPECTS OF CANCER THERAPY**
**For:** Physicians, Pharmacists, Diet./Nutritionists, Oncol. Nurses. Symposium, March 18, 1978, Rush-Presbyterian-St. Luke's Medical Center, Chicago, IL. **Hrs. of Instr.:** 6. **CME Credit:** AMA Category 1. **Fee:** None. **Reg. Deadline:** March 1, 1978. **Reg. Limit:** 130. **Sponsor:** Rush Cancer Center, 1725 West Harrison, Room 820, Chicago, IL. **Co-Sponsor:** Travenol Laboratories. **Contact:** Barbara Palac, Education Coordinator. **Telephone:** 942-6028.

### *Psychiatry*

**ILLINOIS PSYCHIARTIC SOCIETY ANNUAL DINNER**
**For:** Psychiatrists. Lecture and Dinner, March 29, 1978; 6:00 PM. Drake Hotel, Chicago, IL. **Speaker:** Paul H. Ornstein, M.D., Professor of Psychiatry, Univ. of Cincinnati. **Reg. Deadline:** March 24, 1978. **Fee:** $17.00. **Sponsor:** Illinois Psychiatric Society, 55 East Monroe, Suite 3510, Chicago, IL. **Contact:** Wendy J. Smith, Adm. Secy. **Telephone:** (312) 782-1654.

### *Surgery*

**SPECIALTY REVIEW IN SURGERY, PART II**
**For:** General Surgeons. Lecture, March 6, 1978, Cook County Graduate School of Medicine, 707 South Wood Street, Chicago, IL. **Speaker:** Robert J. Baker, M.D. **Hrs. of Instr.:** 99. CME Category 1. **Fee:** $400.00. **Reg. Limit:** 300. **Sponsor:** Cook County Graduate School of Medicine, 707 South Wood Street, Chicago, IL. **Contact:** Robert J. Baker, M.D., Dean. **Telephone:** (312) 733-2800.

### *Urology*

**SECOND ANNUAL UROLOGY CONFERENCE**
**For:** Urologists. 3-day conference, March 3-5, 1978, Alumni Center for Continuing Education, 301 East Chicago Ave., Chicago, IL. **Hrs. of Instr.:** 18. **CME Credit:** AMA Category 1. **Fee:** $150.00. **Sponsor:** Northwestern University Medical School, Alumni Center for Continuing Education, 301 East Chicago Ave., Chicago, IL. **Contact:** James E. Dyson, Ph.D., Director, Continuing Education. **Telephone:** (312) 649-8533.

## APRIL

### *Bioavailability*

**PRACTICAL ASPECTS OF BIOAVAILABILITY**
**For:** Physicians. 1-day conference, April 15, 1978, Drake Hotel—Lake Shore Drive & Michigan Ave., Chicago, IL. **Hrs. of Instr.:** 7. **CME Credit:** AMA Category 1. **Fee:** $15.00. **Sponsor:** Northwestern University Medical School, Alumni Center for Continuing Education, 301 East Chicago Ave, Chicago, IL. **Contact:** James E. Dyson, Ph.D., Director, Continuing Education. **Telephone:** (312) 649-8533.

### *Cardiology*

**ADVANCED EKG**
**For:** Internists and Family Practitioners. Lecture, April 3, 1978, Cook County Graduate School. **Speaker:** Kenneth Rosen, M.D. **Hrs. of Instr.:** 17. **CME Credit:** AMA Category 1. **Fee:** $125.00. **Sponsor:** Cook County Graduate School of Medicine, 707 Wood Street, Chicago, IL. **Contact:** Robert J. Baker, M.D., Dean. **Telephone:** (312) 733-2800.

### *General Medicine*

**CARDIAC STRESS TESTING**
**For:** Physicians. Lecture, April 4, 1978, Henrotin Hospital Board Room, Chicago, IL. **Speaker:** Rimgaudas Nemickas, M.D., Cardiologist. **Hrs. of Instr.:** 1. **CME Credit:** AMA Category 2. **Fee:** None. **Sponsor:** Henrotin Hospital, 111 West Oak Street, Chicago, IL. **Contact:** William N. Werner, M.D. Associate Director of Medical Education. **Telephone:** (312) 440-7755.

### *Internal Medicine*

**STATE & NATIONAL BOARD REVIEW, BASIC**
**For:** Internists. Lecture, April 30, 1978, Cook County Graduate School. **Speaker:** Sheldon S. Waldstein, M.D. **Hrs. of Instr.:** 58. **CME Credit:** AMA Category 1. **Fee:** $250.00. **Reg. Limit:** 150. **Sponsor:** Cook County Graduate School of Medicine, 707 South Wood Street, Chicago, IL. **Contact:** Robert J. Baker, M.D., Dean. **Telephone:** (312) 733-2800.

### *Internal Medicine-Cardiology*

**BASIC SEMINAR AND WORKSHOP IN ECHOCARDIOGRAPHY**
**For:** Internists. Lecture, April 19, 1978, Cook County Graduate School. **Speaker:** Neil E. Kramer, M.D. **Hrs. of Instr.:** 22. **CME Credit:** AMA Category 1. **Fee:** $225.00. **Reg. Limit:** 75. **Sponsor:** Cook County Graduate School of Medicine, 707 South Wood Street, Chicago, IL **Contact:** Robert J. Baker, M.D., Dean. **Telephone:** (312) 733-2800.

### *Pediatric*

**SPECIALTY REVIEW IN PEDIATRICS**
**For:** Pediatricians. Lecture, April 3, 1978, Coo
County Graduate School. **Speaker:** Ira DuBrow, M.D
**Hrs. of Instr.:** 42. **CME Credit:** AMA Category
**Fee:** $225.00. **Reg. Limit:** 200. **Sponsor:** Cook Cou
ty Graduate School of Medicine, 707 South Woo
Street, Chicago, IL. **Contact:** Robert J. Baker, M.D
Dean. **Telephone:** (312) 733-2800.

### *Psychiatr*

**BASIC REVIEW IN PSYCHIATRY**
**For:** Psychiatrists. Lecture, April 3, 1978, Cook Cou
ty Graduate School of Medicine. **Speaker:** Domeena
Renshaw, M.D. **Hrs. of Instr.:** 40. **CME Credi**
AMA Category 1. **Fee:** $200.00. **Reg. Limit:** 10
**Sponsor:** Cook County Graduate School of Medicin
707 South Wood Street, Chicago, IL. **Contact:** Ro
ert J. Baker, M.D., Dean. **Telephone:** (312) 733-280

### *Psychiatr*

**PSYCHIATRY IN THE 1980's**
**For:** Psychiatrists, Physicians and all Mental Heal
Professionals. Lecture/symposium, April 15, 197
8:30 AM-12:30 PM, Maywood, IL. **Hrs. of Instr.:**
**CME Credit:** AMA Category 1. **Fee:** $15.00. **Sponso**
Loyola University, Stritch School of Medicine, Dep
of Psychiatry, 2160 South First Avenue, Maywoo
IL. **Contact:** Jackson A. Smith, M.D. **Telephone:** (31
531-3272.

### *Radiolog*

**DIAGNOSTIC RADIOLOGY**
**For:** Radiologists. Lecture, April 3, 1978, Cook Cou
ty Graduate School. **Speaker:** Roger D. Pinc, M.
**Hrs. of Instr.:** 35. **CME Credit:** AMA Category
**Fee:** $200.00. **Reg. Limit:** 45. **Sponsor:** Cook Coun
Graduate School of Medicine, 707 South Wood Stre
Chicago, IL. **Contact:** Robert J. Baker, M.D., Dea
**Telephone:** (312) 733-2800.

### *Surger*

**FIBEROPTIC ESOPHAGOGASTRIC ENDOSCOPY**
For: Surgeons and Internists. Lecture, April 17, 197
Cook County Graduate School. **Speaker:** C. Thom
Bombeck, M.D. **Hrs. of Instr.:** 19½. **CME Cred**
AMA Category 1. **Fee:** $250.00. **Reg. Limit:** 1
Sponsor: Cook County Graduate School of Medicin
707 South Wood Street, Chicago, IL. **Contact:** Ro
ert J. Baker, M.D. **Telephone:** (312) 733-2800.

### *Surger*

**FIBEROPTIC COLONSCOPY**
**For:** Surgeons, Internists and Family Practitione
Lecture, April 12, 1978, Cook County Gradua
School. **Speaker.** Herand Abcarian, M.D. **Hrs.**
Instr.: 19. **CME Credit:** AMA Category 1. **Fe**
$250.00. **Reg. Limit:** 15. **Sponsor:** Cook Cou
Graduate School of Medicine, 707 South Wood Stre
Chicago, IL. **Contact:** Robert J. Baker, M.D., Dea
**Telephone:** (312) 733-2800.

### *Urolog*

**SPECIALTY REVIEW IN UROLOGY**
**For:** Urologists. Lecture, April 10, 1978, Cook Cou
ty Graduate School. **Speaker:** Irving M. Bush, M.
**Hrs. of Instr.:** 40. **CME Credit:** AMA Category
**Fee:** $225.00. **Reg. Limit:** 150. **Sponsor:** Cook Cou
ty Graduate School of Medicine, 707 South Wo
Street, Chicago, IL. **Contact:** Robert J. Baker, M.D
Dean. **Telephone:** (312) 733-2800.

## MAY

### *Anesthesia*

**ECIALTY REVIEW IN ANESTHESIOLOGY**
r: Anesthesiologists. Lecture, May 14, 1978, Cook unty Graduate School of Medicine. **Speaker:** Alon Winnie, M.D. **Hrs. of Instr.:** 45. **CME Credit:** MA Category 1. **Fee:** $250.00. **Reg. Limit:** 300. onsor: Cook County Graduate School of Medicine, 7 South Wood Street, Chicago, IL. **Contact:** Robert Baker, M.D., Dean. **Telephone:** (312) 733-2800.

### *Contemporary Medical And Surgical Management*

**RATHYROID DISORDERS**
r: Physicians, Residents and Fellows. 2½-day mposium, May 12, 13, 1978, Saint Joseph Hos-tal, 2900 North Lake Shore Drive, Chicago, IL. eaker: Franklin D. Schwartz, M.D. and Louis T. nta, M.D. **Hrs. of Instr.:** 18. **CME Credit:** AMA tegory 1. **Reg. Deadline:** April 14, 1978. **Reg.** mit: 250. **Fee:** $50.00-$250.00. **Sponsor:** Medical ucation Saint Joseph Hospital, 2900 North Lake ore Drive, Chicago, IL. **Contact:** Sharon Afable, min. Asst., Medical Education. **Telephone:** (312) 5-3454.

### *Dermatology*

**SIC DERMATOLOGY**
r: Dermatologists. Lecture, May 1, 1978, Cook unty Graduate School of Medicine, 707 South od Street, Chicago, IL. **Speaker:** Marshall Blanken-p, M.D. **Hrs. of Instr.:** 35. **CME Credit:** AMA tegory 1. **Reg. Limit:** 100. **Fee:** $200.00. **Sponsor:** ok County Graduate School of Medicine. **Contact:** bert J. Baker, M.D., Dean. **Telephone:** (312) 733-00.

### *Dermatology*

**IMARY CARE DERMATOLOGY**
r: All physicians. Conference, May 19-21, 1978, icago, IL. **Hrs. of Instr.:** 17. **CME Credit:** AMA tegory 1. **Reg. Limit:** 250. **Fee:** $150.00. **Sponsor:** rthwestern University Medical School, Center for ntinuing Education, 301 East Chicago Ave., Chi-go, IL. **Contact:** James E. Dyson, Ph.D., Director Continuing Education. **Telephone:** (312) 649-8533.

### *Family Medicine*

**th ANNUAL POSTGRADUATE SEMINAR**
r: Family Physicians. Lecture and Seminars, May 8, 1978, Hyatt Regency Chicago, Chicago, IL. s. of Instr.: 16-22. **CME Credit:** AMA Category 1 d AAFP Prescribed. **Fee:** $20.00. **Sponsor:** Illinois ademy of Family Physicians, 1200 Harger Road, ite 405; Oak Brook, IL. **Contact:** H. Marchmont-binson, M.D., Executive Director. **Telephone:** (312) 5-8502.

### *Internal Medicine*

**IDWESTERN STUDY CONFERENCE**
r: Internists and General Practitioners. Lecture, ay 11-13, 1978, Chicago, IL. **Speaker:** Ward E. rrin, D.O. **Hrs. of Instr.:** 18. **CME Credit:** AOA ending). **Fee:** $125.00. **Sponsor:** Chicago College Osteopathic Medicine, 5206 South University, icago, IL. **Co-Sponsor:** American College of Osteo-thic Internists. **Contact:** Marie E. Kowalsky, Di-ctor of Special Events. **Telephone:** (312) 947-4606.

### *Internal Medicine*

**NIVERSITY OF MICHIGAN AND GUEST FACULTY—ITERNAL MEDICINE**
r: Internists. 5-day workshop course, May 22-26, 78. Towsley Center, Ann Arbor, MI. **Hrs. of Instr.:** ½. **CME Credit:** AAFP Elective, AMA Category 1 d ADA Elective. **Fee:** $250.00. **Sponsor:** Office of ntinuing Education, Dept. of Postgrad. Med. & alth Prof. Education, Towsley Center, U-M, Ann bor, MI. **Contact:** Connie Miller, Secretary. **Tele-one:** (312) 763-1423.

### *Internal Medicine*

**PECIALTY REVIEW COURSE IN HEMATOLOGY**
r: Hematologists. Lecture, May 15, 1978, Cook unty Graduate School of Medicine, 707 South od Street, Chicago, IL. **Speaker:** William J. onnelly, M.D. **Hrs. of Inst.:** 40. **CME Credit:** AMA tegory 1. **Reg. Limit:** 150. **Fee:** $200.00. **Sponsor:** ok County Graduate School of Medicine, Chicago, . **Contact:** Robert J. Baker, M.D., Dean. **Telephone:** 12) 733-2800.

### *Internal Medicine*

**SPECIALTY REVIEW COURSE IN INFECTIOUS DISEASE**
**For:** Infectious Disease Specialists. Lecture, May 15, 1978, Cook County Graduate School of Medicine, 707 South Wood Street, Chicago, IL. **Speaker:** Stuart Levin, M.D. **Hrs. of Instr.:** 40. **CME Credit:** AMA Category 1. **Reg. Limit:** 150. **Fee:** $200.00. **Sponsor:** Cook County Graduate School of Medicine. **Contact:** Robert J. Baker, M.D., Dean. **Telephone:** (312) 733-2800.

### *Internal Medicine*

**SPECIALTY REVIEW COURSE IN NEPHROLOGY**
**For:** Nephrologists. Lecture, May 8, 1978, Cook County Graduate School of Medicine, 707 South Wood Street, Chicago, IL. **Speaker:** Norman Simon, M.D. **Hrs. of Instr.:** 40. **CME Credit:** AMA Category 1. **Reg. Limit:** 150. **Fee:** $200.00. **Sponsor:** Cook County Graduate School of Medicine. **Contact:** Robert J. Baker, M.D., Dean. **Telephone:** (312) 733-2800.

### *Internal Medicine*

**SPECIALTY REVIEW COURSE IN RHEUMATOLOGY**
**For:** Rheumatologists. Lecture, May 8, 1978, Cook County Graduate School of Medicine, 707 South Wood Street, Chicago, IL. **Speaker:** Herbert M. Rubinstein, M.D. **Hrs. of Instr.:** 40. **CME Credit:** AMA Category 1. **Reg. Limit:** 150. **Fee:** $200.00. **Sponsor:** Cook County Graduate School of Medicine. **Contact:** Robert J. Baker, M.D., Dean. **Telephone:** (312) 733-2800.

### *Internal Pulmonary Medicine*

**SPECIALTY REVIEW COURSE IN PULMONARY DISEASE**
**For:** Pulmonary Specialists. Lecture, May 1, 1978, Cook County Graduate School of Medicine, 707 South Wood Street, Chicago, IL. **Speaker:** John T. Sharp, M.D. **Hrs. of Instr:** 40. **CME Credit:** AMA Category 1. **Reg. Limit:** 150. **Fee:** $200.00. **Sponsor:** Cook County Graduate School of Medicine. **Contact:** Robert J. Baker, M.D., Dean. **Telephone:** (312) 733-2800.

### *Neuromuscular Diseases*

**NEUROMUSCULAR DISEASES**
**For:** Practicing Physicians, General and Family Physical Rehabilitation. Symposium, May 19-20, 1978, Wohl Auditorium, Barnes Hospital Complex, St. Louis, MO. **Hrs. of Instr.:** 12. **CME Credit:** AAFP and AMA Category 1. **Fee:** $120.00. **Sponsor:** Washington University School of Medicine, Office of Continuing Medical Education, Box 8063, 660 South Euclid, St. Louis, MO. **Contact:** Loretta Giacoletto, Administrative Coordinator. **Telephone:** (314) 367-9673.

### *Neurosurgery*

**SECOND ANNUAL POSTGRADUATE COURSE IN PEDIATRIC NEUROSURGERY**
**For:** Neurosurgeons. Conference, May 2-6, 1978, Chicago, IL. **Hrs. of Instr.:** 35. **CME Credit:** AMA Category 1. **Reg. Limit:** 250. **Fee:** $315.00. **Sponsor:** Northwestern University Medical School, Center for Continuing Education, 301 East Chicago Ave., Chicago, IL. **Contact:** James E. Dyson, Ph.D., Director of Continuing Education. **Telephone:** (312) 649-8533.

### *Obstetrics/Gynecology*

**SPECIALTY REVIEW IN OBSTETRICS AND GYNECOLOGY**
**For:** Gynecologists and Obstetricians. Lecture, May 15, 1978, 8:00 AM, Cook County Graduate School of Medicine, Chicago, IL. **Speaker:** John G. Masterson, M.D. **Hrs. of Instr.:** 83. **CME Credit:** AMA Category 1. **Reg. Limit:** 125. **Fee:** $400.00. **Sponsor:** Cook County Graduate School of Medicine, 707 South Wood Street, Chicago, IL. **Contact:** Robert J. Baker, M.D., Dean. **Telephone:** (312) 733-2800.

### *Pediatrics*

**THE HIGH RISK INFANT**
**For:** Physical Therapists and Other Health Professionals. 2-day workshop course, May 4-5, 1978, 8:00 AM-5:00 PM. **Hrs. of Instr.:** 12. **CME Credit:** AAFP Elective, AMA Category 1 and ADA Elective. **Sponsor:** Office of Continuing Education, Dept. of Postgrad. Med. & Health Prof. Education, Towsley Center, U-M, Ann Arbor, MI. **Contact:** Connie Miller, Secretary. **Telephone:** (313) 763-1423.

### *Medicine*

**FAMILY PRACTICE REVIEW**
**For:** Family Practitioners. Lecture, May 15, 1978. **Speaker** H. Marchmont-Robinson, M.D. **Hrs. of Instr.:** 45. **CME Credit:** AMA Category 1. **Reg. Limit:** 125. **Fee:** $200.00. **Sponsor:** Cook County Graduate School of Medicine. **Contact:** Robert J. Baker, M.D., Dean. **Telephone:** (312) 733-2800.

### *Medicine*

**STATE AND NATIONAL BOARD REVIEW, CLINICAL**
**For:** Internists and Family Practitioners. Lecture, May 8, 1978, Cook County Graduate School of Medicine, 707 South Wood Street, Chicago, IL. **Speaker:** Sheldon S. Waldstein, M.D. **Hrs. of Instr.:** 53. **CME Credit:** AMA Category 1. **Reg. Limit:** 150. **Fee:** $250.00. **Sponsor:** Cook County Graduate School of Medicine. **Contact:** Robert J. Baker, M.D., Dean. **Telephone:** (312) 733-2800.

### *Musculo-Skeletal Trauma*

**CLINICAL HOSPITAL PROGRAM ON MUSCULO-SKELETAL TRAUMA**
**For:** All Physicians. Lecture, May 11, 1978, 8:00-10:00 PM, John B. Murphy Auditorium, 50 East Erie Street, Chicago, IL. **Hrs. of Instr.:** 2. **CME Credit:** AAFP Elective and AMA Category 1. **Fee:** None. **Sponsor:** Chicago Committee on Trauma of the American College of Surgeons, 11255 West 74th Street, LaGrange, IL. **Co-Sponsor:** University of Chicago Hospital & Clinics. **Contact:** Mrs. Lillian Husa, Executive Secretary. **Telephone:** (312) 482-8686.

### *Pediatric Surgery*

**THIRD ANNUAL SYMPOSIUM ON SURGICAL PROBLEMS IN CHILDREN**
**For:** Surgeons, Pediatricians, F.P., G.P. Symposium. May 18, 1978, Wohl Auditorium, Barnes Hospital Complex, St. Louis, MO. **Hrs. of Instr.:** 6. **CME Credit:** AAFP and AMA Category 1. **Reg. Limit:** 150. **Fee:** $60.00. **Sponsor:** Washington University School of Medicine, Office of Continuing Medical Education, Box 8063, 660 South Euclid, St. Louis, MD. **Contact:** Loretta Giacoletto, Administrative Coordinator. **Telephone:** (314) 367-9673.

### *Psychiatry*

**NEUROTRANSMITTER RECEPTORS AND SCHIZOPHRENIA**
**For:** Psychiatrists and Mental Health Professionals. Lecture series, May 17, 1978, 8:00 PM, Offield Auditorium, Passavant Pavilion, 303 East Superior St., Chicago, IL. **Speaker:** Solomon Snyder, M.D., Prof. of Psych. and Pharmacology. **Hrs. of Instr.:** 1½. **CME Credit:** AMA Category 1. **Fee:** None. **Sponsor:** Institute of Psychiatry, Northwestern University Medical School, 320 East Huron Street, Chicago, IL. **Contact:** Leon Diamond, M.D., Director of Graduate Education. **Telephone:** (312) 649-8058.

### *Radiology*

**REFRESHER COURSE IN DIAGNOSTIC RADIOLOGICAL PHYSICS**
**For:** Radiologists. Lecture, May 15, 1978, 8:00 AM, Cook County Graduate School of Medicine. **Speaker:** Theodore Fields, M.S. **Hrs. of Instr.:** 44. **CME Credit:** AMA Category 1. **Reg. Limit:** 75. **Fee:** $250.00. **Sponsor:** Cook County Graduate School of Medicine, 707 South Wood Street, Chicago, IL. **Contact:** Robert J. Baker, M.D., Dean. **Telephone:** (312) 733-2800.

### *Surgery*

**ADVANCES IN SURGERY**
**For:** Surgeons. Lecture, May 8, 1978, 8:00 AM, Cook County Graduate of Medicine, Chicago, IL. **Speaker:** Robert J. Baker, M.D. **Hrs. of Instr.:** 40. **CME Credit:** AMA Category 1. **Reg. Limit:** 100. **Fee:** $200.00. **Sponsor:** Cook County Graduate School of Medicine, 707 South Wood Street, Chicago, IL. **Contact:** Robert J. Baker, M.D., Dean. **Telephone:** (312) 733-2800.

### *Surgery*

**GYNECOLOGICAL LAPAROSCOPY**
**For:** Surgeons and Gynecologists. Lecture. May 24, 1978, 9:00 AM, Illinois Masonic Hosptal, Chicago, IL. **Speaker:** John J. Barton, M.D. **Hrs. of Instr.:** 18. **CME Credit:** AMA Category 1. **Reg. Limit:** 8. **Fee:** $250.00. **Sponsor:** Cook County Graduate School of Medicine, 707 South Wood Street, Chicago, IL. **Contact:** Robert J. Baker, M.D., Dean. **Telephone:** (312) 733-2800.

### *Urology*

**CLINICAL PROBLEMS IN UROLOGY**
**For:** Physicians. Lecture, May 10, 1978, 2:00-5:00 PM, 950 East 59th Street, Chicago, IL: **Hrs. of Instr.:** 3. **CME Credit:** AAFP Elective and AMA Category 1. **Fee:** $20.00. **Sponsor:** The University of Chicago, Frontiers of Medicine, 950 East 59th Street, Chicago, IL. **Contact** Elaine Ehrman, Secretary. **Telephone:** (312) 947-5777.



# new pharmaceutical specialties

By Paul Dehaen

For detailed information regarding indications, dosage, contraindications and adverse reactions, refer to the manufacturer's package insert or brochure.

**New Single Drugs**—Drugs not previously known, including new salts.

**Duplicate Single Drugs**—Drugs marketed by more than one manufacturer.

**Combination Products**—Drugs consisting of two or more active ingredients.

**New Dosage Forms**—Of a previously introduced product.

**The following new drugs have been marketed:**

## NEW SINGLE DRUGS

**FLEXERIL** — Muscle Relaxant Rx

| | |
|---|---|
| Manufacturer: | Merck Sharp & Dohme |
| Nonproprietary Name: | Cyclobenzaprine HCl |
| Indications: | Muscle spasm with acute painful musculoskeletal conditions |
| Contraindications: | Concomitant use of monoamine oxidase inhibitors or within 14 days after their discontinuance, Cardiovascular disorders. |
| Dosage: | Oral; 10 mg tid |
| Supplied: | Tablets, 10 mg |

## DUPLICATE SINGLE DRUGS

**RUBACELL** — Diagnostic Rx

| | |
|---|---|
| Manufacturer: | Abbott Laboratories |
| Nonproprietary Name: | Rubella virus antigen sensitized cells |
| Indications: | Immunity screening for rubella (German Measles) |
| Operation: | 100 Rubacell tests take 35 minutes attended time plus two hours of unattended incubation |
| Supplied: | Test kit. |

**A-POXIDE** — Tranquilizer Rx

| | |
|---|---|
| Manufacturer: | Abbott Laboratories |
| Nonproprietary Name: | Chlordiazepoxide HCl |
| Indications: | Anxiety and tension |
| Dosage: | Adults, 5 to 10 mg 3 to 5 times daily |
| Supplied: | Capsules, 5, 10 and 25 mg |

**DEXACEN-LA-8** — Corticoid Rx

| | |
|---|---|
| Manufacturer: | The Central Pharmacal Co. |
| Nonproprietary Name: | Dexamethasone Acetate |
| Indications: | Diseases responding to long-acting corticosteroid therapy |
| Contraindications: | Systemic fungal infections |
| Dosage: | See package insert |
| Supplied: | Multiple dose vial, 5 ml |

**DEXACEN-4** — Corticosteroid Rx

| | |
|---|---|
| Manufacturer: | The Central Pharmacal Co. |
| Nonproprietary Name: | Dexamethasone sod. phosphate inj. |
| Indications: | Diseases responding to corticosteroid therapy |
| Contraindications: | Systemic fungal infections |
| Dosage: | See package insert |
| Supplied: | Multiple dose vial, 10 mg ml/4 mg |

**DRAMOCEN** — Antinauseant Rx

| | |
|---|---|
| Manufacturer: | The Central Pharmacal Co. |
| Nonproprietary Name: | Dimenhydrinate inj. |
| Indications: | Prophylaxis and treatment of motion sickness |
| Contraindications: | Do not inject intra-arterially |
| Dosage: | Adults, initial, 50 mg, repeated every 4 hours |
| Supplied: | Multiple dose vial, 10 ml; ml/50 mg |

**ROBAMOX Caps. and Susp.**

| | |
|---|---|
| Manufacturer: | A. H. Robins Company |
| Nonproprietary Name: | Amoxicillin |
| Indications: | Infections due to susceptible strains of Gram positive and negative organisms |
| Dosage: | Adults, 250 mg every eight hours<br>Children, 21 mg/kg day depending upon response |
| Supplied: | Capsules, 250 and 500 mg<br>Oral suspension, 125/5 ml and 250 mg/5 ml |

## COMBINATION PRODUCTS

**DI-PRED** — Corticoid Rx

| | |
|---|---|
| Manufacturer: | The Central Pharmacal Co. |
| Composition: | *Each ml.*<br>Prednisone acetate 80 mg<br>Prednisolone sd. phosphate 20 mg |
| Indications: | Endocrine disorders |
| Contraindications: | Systemic fungal infections |
| Dosage: | Depends on severity and response of the patient<br>Given im, ia or isnovial |
| Supplied: | Aqueous suspension<br>Multiple dose vial, 10 ml |

NONPARTISAN

# IMPAC

**ILLINOIS MEDICAL POLITICAL ACTION COMMITTEE**
55 East Monroe Street
Chicago, Illinois 60603
312/782-1963

## *Mark Your Calendar*

*Tuesday, April 4, 1978*

*Chicago Palmer House Hotel*

## *1978 IMPAC/AMPAC Regional Workshop*

*At the ISMS Annual Meeting*

featuring

## *Susan Bryant*

Washington Public Affairs Consultant

## *Honorable George O'Brien*

Member of Congress
(Illinois-17th District)

Contributions are not limited to the suggested amount. Neither the Illinois State Medical Society nor the AMA will favor or disadvantage anyone based upon the amounts of or failure to make pac contributions. Copies of IMPAC & AMPAC reports are filed with the Federal Election Commission, Washington, D.C. Contributions are subject to the limitations of FEC regulations, Sections 110.1, 110.2 & 110.5. (Federal regulations require this notice.) IMPAC reports are also filed with the State Board of Elections, and are or will be available for purchase from the State Board of Elections, 1020 S. Spring St., Springfield, Illinois, 62704



# Seminars In Immunopathology and Oncology

RICHARD J. ABLIN, PH.D., CONTRIBUTING EDITOR

# *Brown Recluse Spider Bites — Some Immunologic Aspects*

BY PHILIP C. ANDERSON, M.D./COLUMBIA, MISSOURI

In 1957, Atkins, from the University of Missouri at Columbia, accurately associated the ulcerative cutaneous disease now called necrotic loxoscelism with the bite of the house spider, *Loxosceles reclusa*.[1] He demonstrated that the ulcer was caused by necrotizing action of the venom and not by infection, as many physicians had claimed. Twenty years earlier, in 1937, before the indexing and translation services of the National Library of Medicine were available, Macchiavello of Chile had described in Spanish the same medical conditions and explained the role of the South American spider, *Loxosceles laeta*. Twenty years more have passed since Atkins' report, and our understanding of loxoscelism has advanced in two regards. First, we now recognize a very mild common bite which was overlooked entirely in earlier reports. We now realize that protective immunity is induced by these bites. Secondly, as physicians, we are beginning to understand the clinical management of systemic loxoscelism and can much better prevent death.

The first conceptual advance in 1973 was the result of Millikan's work in the development of an accurate and reliable *in vitro* lymphocyte transformation test.[2] Clinical advances have resulted from a slow accumulation of experience with severe systemic loxoscelism.[3-6] This work has been recently stimulated by excellent progress in basic laboratory studies by investigators using purified venoms and working with isolated mammalian cells. This review will discuss the venom, new concepts in pathogenesis, humoral immunity, cellular immunity, and a brief summary of the proper conservative management of loxoscelism.

## The Venom

The isolation of pure skin-necrotizing factor (SNF) from whole venom is difficult.[7-11] About 99.98% of whole venom is composed of various spreading factors and other enzymes. The active 0.02% is far more valuable than pure gold. Compared to other venoms, the pure SNF is a large, complex, protein molecule of about 30,000 Daltons. The structure has not been discovered but it may resemble that class of large enzymes able to attack complex lipids. Our first goal is

PHILIP C. ANDERSON, M.D., is a professor and chairman of the Department of Dermatology at the University of Missouri Medical Center in Columbia, Missouri.

a better understanding of the venom. Promising studies are underway to discover a means to block the action of the venom on the erythrocyte. Such a medication might arrest systemic loxoscelism. The problem of a medication to prevent rapid injury to skin capillaries by venom is less tractable. To protect the individual who is exposed often to the bite of *Loxosceles,* the best approach may be to modify the venom to achieve a safe antigen for active immunization. At present, no studies exist of experimentally induced immunity using natural venom.

## New Concepts in Pathogenesis

The primary injury to human tissues by *Loxosceles* venom is caused by the enzyme-like action of cell membranes on the lipids.[12] The important initial site of action in skin is on the capillaries, causing destruction of the endothelium, rapid clotting and necrosis of the vessel with its nearby branches.[13] This vascular collapse does not depend on clotting alone and the various means of blocking blood coagulation cannot prevent it. No method is known for preventing initial destruction of the skin capillaries by spider venom.

Dispersion of venom and extension of necrosis in the skin seem to be importantly different in man than in other animals because of the complex, thick, vascular and cellular dermis of humans as compared to the simpler, thinner skin of a rabbit or guinea pig. Even very small doses of venom cause areas of necrosis in the rabbit while humans regularly tolerate mild *Loxosceles* bites without necrosis. Almost all *Loxosceles* bites in humans are benign medically. Even seemingly extensive bites may suddently arrest their progress, impending necrosis may abort and the damaged area heals well with no treatment. As discussed elsewhere, routine early excision of *Loxosceles* bites is neither a logical nor demonstrably effective treatment. We suspect that dispersion of venom in the human dermis is rapid and know that the areas of dispersion are not coincident with the area of necrosis. Apparently, the dermis is capable of neutralizing some venom; dispersion seems to be a healthy defense and not an indication for ever-wider excision. Further studies of the spread of spider venom in the skin of a suitable test animal, such as the pig, will be valuable. These await proper tagging of the necrotizing portion of the venom.

Hemolysis is induced directly by *Loxosceles* venom destroying the erythrocyte membrane.[12] In children, within eight hours after a severe spider bite, the hematocrit may drop from 40% to 5 or 10%. Flank pain may be severe and the child sleepy and pale but rarely jaundiced. The next events may be deepening coma, intravascular coagulation, anuria, and death—the familiar sequence of a fatal *Loxosceles* bite. However, extensive hemolysis and anuria may ensue without substantial coagulation system anomalies. Evaluating progressive hemolysis by measurements of free serum hemoglobin is one device for selecting those patients with spider bites who may be developing severe or progressive systemic loxoscelism. Hemolysis always occurs in the skin around the bite and may contribute secondarily to local necrosis, although the mechanisms are not yet understood.

Renal injury usually occurs when hemolysis is severe. However, mild hematuria and albuminuria have been demonstrated repeatedly in cases where hemolysis was not detected. Venom may have some direct action on the kidneys. Such speculations will be resolved by studies using purified venom and isolated organ systems. The well-discussed mechanisms by which hemolysis may cause anuria are still speculative. Peritoneal dialysis greatly benefits patients who have anuria associated with hemolysis induced by the venom of *Loxosceles.*

For decades, clinicians have considered necrosis of body fat to be a danger sign when part of the initial spider bite. Campbell's demonstration that *Loxosceles* venom can attack lipids strengthens hypotheses that some fragment of human adipose lipids mediates some portion of systemic loxoscelism. The important details and methods of treatment depend on further laboratory studies. In certain atypical cases of systemic loxoscelism clinical features suggest embolic phenomona which, in the absence of clotting abnormality, may possibly be explained by fat emboli.

## Humoral Immunity

Active cutaneous loxoscelism is induced mainly by the direct action of venom on cells and does not require any components of the immune system. When the immune system is involved, it protects against the venom. Giving repeatedly small doses of venom to rabbits or guinea pigs will induce protection against large doses of venom. Protection is induced by injecting cell-free immune serum to a susceptible animal just prior to envenomization. Mixing immune serum

with venom destroys its necrotizing properties. Clinically, humans who have endured a few bites by *Loxosceles* over several years appear to be well-protected, presumably by active humoral immunity to the venom. Human skin testing to evaluate this immune protection has not been done.

The classes of antibodies which are protective in humans or the types of reactions between antibody and venom have not been well studied. Protective immunization of humans who are frequently exposed to the spiders seems viable, but a practical method awaits better purification or some modifications of the venom to lessen necrotizing effects. Further evaluations of effectiveness are needed.

### Cellular Immunity

The lymphocytes of an individual who has never been exposed to *Loxosceles* species venom will not display lymphocyte transformation activity *in vitro* to the venom. The test is sensitive and specific. For about five days after the bite, the lymphocytes remain unmodified in all patients, which allows verification of their immune status prior to the bite. Between two weeks and 10 weeks after the bite, all patients will develop the delayed or cellular sensitization to venom which then persists for most of the lifetime. Millikan and his associates developed and studied this useful lymphocyte transformation test in 1973.[2] The clinician could distinguish between various necrotic bites with this method and, more importantly, between necrotizing cutaneous infections and true loxoscelism. Antibiotics are routinely helpful when the diagnosis of infection is accurate; antibiotics have no beneficial action on simple cutaneous loxoscelism.[5]

Some neglected areas of study in spider bite immunology include lymphocyte reactivity to venom in experimental animals, effects of lymphocyte suppression on the early development of humoral protection, and the nature of T and B cell interactions in venomous diseases. It is dubious that cellular immunity itself has any protective action against an acute brown spider bite; however, the role of lymphocytes in preventing some aspects of systemic loxoscelism remains to be studied.

### Practical Management of the Spider Bite

The actual bite of the spider may not be felt at all or is noted as a minor injury to the skin, such as the puncture of a wood splinter. However, after about six hours, spider bites range between very tender and extremely painful; never are they painless. The milder, less necrotic lesions are red papules or nodules, sometimes with a vesicle or bleb at the bite and often with some dermal hemorrhage visible at the surface. As the lesion worsens, the center necroses, becomes blue or purple, widens, loses the translucency of living skin, and gradually sinks below the normal skin level. At this time pain is worsening, the area involved appears to be expanding quickly, and hemorrhage at the active margin may be extensive. From work in animals it appears that the flow of the venom in the skin is well ahead of the demarcation of the necrotic area. The much thicker, more vascular skin of humans distributes and binds the venom more rapidly than does the skin of a rabbit.

I do not advise early excision aimed at stopping the progress of the bite. One reason is that the benefits usually are far less than expected and the disturbance to the patient's working schedule as well as the medical costs are comparatively great. In most instances, surgery is not needed and if done must be considered expensive overtreatment. Only a very few bites become large or induce systemic loxoscelism. To rely on excision, one must predict which bites are the ones destined to progress to full size. I am unaware of any such accurate, predictive procedures. Nearly all *Loxosceles* bites are best managed conservatively. Late reparative skin grafting is useful and can be considered about six weeks after natural healing has been evaluated.

What should be done for the mild to moderate bite? Except for pain medication and appropriate safety precautions, there is no necessary treatment for spider bites when the necrotic center is less than approximately two centimeters across. The patient merits close follow-up, reassurance, rest, and general care.

What about the large or massive bites? As we observed in animal investigations and may extrapolate to humans, I doubt that systemic steroids given at the earliest possible time reduce by much the necrosis in the skin after severe envenomation. However, I do think the pain and damaging reaction around the bite are lessened. The important question is: Does early steroid medication prevent inappropriate coagulation or renal injury? The answer, in my opinion, is that steroids are useful in preventing these problems if given promptly. At least tentatively, I would suggest that steroids be given

at the earliest opportunity anytime during the first five days of massive loxoscelism, particularly if renal or coagulation problems seem to be emerging. After five days, the damaging active phase of loxoscelism usually is completed. Until more comprehensive understanding of these severe cases is available, we should trust our cooperative clinical impressions and employ steroids by the usual guidelines and cautions, particularly when the risk of short-term steroid therapy in young adults is so small and the total cost low. ◄

**References**


1. Atkins, J. A., Wingo, C. W. and Sodemann, W. A.: "Probable Cause of Necrotic Spider Bite in the Midwest," *Science* 126:73, 1957.
2. Berger, R. S., Millikan, L. E. and Conway, F.: "An *In Vitro* Test for *Loxosceles Reclusa* Spider Bites," *Toxicon* 11:465-470, 1973.
3. Majeski, J. A. and Durst, G. G., Sr.: "Necrotic Arachnidism," *Southern Medical Journal* 69 (7) :887-891, 1976.
4. Simmons, R. and Curtin, J. W.: "Brown Recluse Spider Bite—Increasing Incidents in Northern Illinois," *Illinois Medical Journal* 145:43-46, 1974.
5. Anderson, P. C.: "What's New in Loxoscelism," *Missouri Medicine* 70:711-712 and 718, 1973.
6. Rose, N. J.: "Report of Fatality, Spider Bite (*Loxosceles*)," *Illinois Medical Journal* 137:339, 1970.
7. Geren, C. R., Chan, T. K., Howell, D. E. and Odell, G. V.: "Isolation and Characterization of Toxins from Brown Recluse Spider Venom (*Loxosceles Reclusa*)," *Archives of Biochemistry and Biophysics* 174 (1):90-99, 1976.
8. Geren, C. R., Chan, T. K., Howell, D. E. and Odell, G. V.: "Partial Characterization of the Low Molecular Weight Fractions of the Extract of the Venom Apparatus of the Brown Recluse Spider and of Its Hemolymph," *Toxicon* 13 (4):233-238, 1975.
9. Elgert, K. D., Ross, M. A., Campbell, B. J. and Barrett, J. T.: "Immunological Studies of Brown Recluse Spider Venom, Infection and Immunity," 10 (6) :1412-1419, 1974.
10. Wright, R. P., Elgert, K. D., Campbell, B. J. and Barrett, J. T.: "Hyaluronidase and Esterase Activities of the Venom of the Poisonous Brown Recluse Spider," *Archives of Biochemistry and Biophysics* 159:415-426, 1973.
11. Suarez, G., Schenone, H. and Socias, T.: "*Loxosceles Laeta* Venom—Partial Purification," *Toxicon* 9:291, 1971.
12. Berger, R. S., Adelstein, E. H. and Anderson, P. C.: "Intravascular Coagulation—The Cause of Necrotic Arachnidism," *Journal of Investigative Dermatology* 61:142-150, 1973.
13. Campbell, B. J., Forrester, L. J. and Barrett, J. T.: "Direct Lysis of Red Blood Cells by the Venom of *Loxosceles Reclusa*," *Federation Proceedings* 36 (3): 669, 1977.



# Army Medicine wants more doctors who specialize.

If you're a physician specializing in pediatrics, anesthesiology, radiology, or internal medicine, we've got a full range of career opportunities for you.

These opportunities are available in a setting that's about as free from non-medical distractions as it's possible for a practice to be. If you're a doctor who's more interested in practicing medicine than the running of a practice, Army Medicine could be perfect for you. Just call your local Army Medical Counselor, and he will discuss specific assignment opportunities with you.

Counselor/Phone Number

Captain Alex Fedorov 312-926-2147

or

Captain George Warneck 314-268-3846

**Army Medicine. The practice that's practically all medicine.**




Edited By JOHN M. BEAL, M.D.

*Surgical Grand Rounds are held weekly on Tuesday at 5:00 p.m. in the Offield Auditorium of the Passavant Pavilion of Northwestern Memorial Hospital. Patient presentations from Northwestern Memorial Hospital and the Veterans Administration Lakeside Hospital form the basis of the discussions. This case report was part of the Surgical Grand Rounds of November 30, 1976.*

## Case Report

# Gastrointestinal Hemorrhage in a Three-Year Old Child

**Dr. Renee Hartz:** A 3½-year-old white male was transferred to Children's Memorial Hospital for treatment of massive upper G.I. bleeding. He had been admitted to another hospital the previous day, after his mother had given him two baby aspirins because he didn't feel well. That same evening the child vomited a large amount of bright red blood and was taken to the emergency room, where he was found to be in shock with a hemoglobin level of 6.8 grams. He was initially stabilized at that hospital with gastric saline gavage and blood transfusions. Bleeding apparently ceased. However, he rebled a few hours later and, after 1500 cc. of blood, he was transferred to Children's Memorial Hospital.

The child's past medical history is significant. He was three to four weeks premature at birth and had an umbilical line for approximately four days, although we have been unable to ascertain whether that was an arterial or venous catheter. One year prior to the present admission, the child had another episode of major upper gastrointestinal bleeding and had been explored at another hospital. The details of that laparotomy are not clear to us, but a few things were evident. He had some free fluid present in his abdomen and some sort of inflammatory mass in the porta hepatis, the nature of which is uncertain. Gastrotomy was performed and there were several superficial erosions in the stomach, but no gross ulcers were seen.

When we first saw this child, the physical examination revealed shock. The child was cold and shivering, with a systolic blood pressure of 80 and a heart rate of 130. The main physical findings were limited to abdominal examination. His abdomen was very protuberant and tense, with an increased venous pattern and questionable fluid wave. He had a firm, enlarged spleen and a slightly enlarged liver. In addition, bright red blood issued from both rectum and his nasogastric tube.

The first three days of treatment at Children's was devoted essentially to critical care management. He did not have any major diagnostic studies in those three days and was in the intensive care unit the entire time. We were able to maintain his hemoglobin level with blood transfusions, his platelet count ranged from 25,000-50,000, and his coagulation profile and liver function were relatively normal.

This 15 kg. child received 2500 cc. of blood in

three days, multiple platelet infusions, fresh frozen plasma, intravenous Pitressin, and on two occasions had a Sengstaken-Blakemore tube in place. On the first occasion, the child stopped bleeding totally, but he started to bleed again and the tube was reinserted. He continued to bleed. Four days after admission, a splenoportogram was performed to further delineate the nature of this child's obvious portal hypertension.

The splenoportogram demonstrated several significant features. The films showed the splenic vein, the inferior mesenteric vein and a poorly visualized superior mesenteric vein. (Figure 1) Most pertinently, his portal vein was really smaller than his splenic vein, which measured six mm. in width. In addition, the interhepatic branches of his portal vein were abnormal; the small vessels terminated somewhat abnormally.

There was a huge coronary vein and multiple varices in the fundus and up into the esophagus. The radiologist reported a possible leak of contrast material in the gastro-esophageal area. The child was taken immediately from the X-ray department to the operating room with the objective of controlling the bleeding rather than doing a definitive operation.



**Figure 1.**
**Splenoportogram demonstrated patient splenic vein and small portal vein. The splenic vein measured 6 mm. in diameter.**

### Surgical Treatment

The child was explored through a bilateral subcostal incision. On entering the abdomen, there was free blood present from the previous splenoportogram. The leak in the spleen was oversewn and attention was turned to the exploration. There were many adhesions from previous surgery which precluded exploration of the porta hepatis. Therefore, an anterior gastrotomy was performed. There were multiple huge bleeding varices in the stomach, but there did not appear to be fresh bleeding from the esophagus. Considerable time and effort were spent oversewing all these individual bleeding varices. After the operation, the child did well, did not bleed again, and was discharged to be followed for future workup and definitive therapy.

He did have a liver biopsy and the liver looked normal.

**Dr. Joseph Sherman:** Portal hypertension as a cause of gastrointestinal bleeding in children is rare. Fortunately, it is usually easy to diagnose, but it can be difficult to treat.

Most gastrointestinal bleeding in preschool children consists of bright red streaking of the stools. It is usually caused by a rectal fissure or a juvenile polyp. Rarely, juvenile polyps produce bowel obstruction or severe lower gastrointestinal bleeding requiring their removal.

Massive upper gastrointestinal bleeding in the preschool child is usually caused by esophageal and gastric varices or, less commonly, by a duodenal ulcer. Both diseases can present with hematemesis, but variceal bleeding should be suspected when the child has signs of portal hypertension, such as a protuberant abdomen, prominent venous collaterals on the anterior abdominal wall and an enlarged spleen.

Children develop portal hypertension from extra-hepatic or intra-hepatic block of the portal vein. Intra-hepatic obstruction is caused by cirrhosis secondary to hepatitis or rarer diseases such as cystic fibrosis and gylcogen storage diseases. Today we are seeing more portal hypertension secondary to cirrhosis in children who have had hepaticoportoenterostomy for biliary atresia.

There are two possible explanations for extrahepatic portal vein obstruction. Early in embryonic life, the portal vein develops from a series of anastomoses between the right and left vitelline veins. Incomplete development of the portal vein can result in portal hypertension.

Umbilical vein catheterization or newborn umbilical infection, omphalitis, may also result

in portal hypertension. The umbilical vein is connected to the portal vein by the ductus venosus. Any inflammation or obstruction of the umbilical vein may involve the portal vein. Recanalization of an obstructed portal vein results in inadequate portal venous blood flow and portal hypertension.

When a preschool child presents with severe upper gastrointestinal bleeding secondary to esophageal varices, the initial treatment is not definitive; in other words, it is not portosystemic shunting. Shunting has not been successful in children less than eight to ten years of age. Typically, a child with extrahepatic portal vein obstruction will present in infancy with ascites and splenomegaly. Their first bleed, which is rather dramatic, occurs at two to four years of age. The initial incident is sudden and almost always controlled by conservative measures. We may see three or four children with varices each year and rarely do we have to "lap" the child to control the bleeding. Normally, we control the bleeding with sedation, irrigation of the stomach with iced saline, transfusion and, if necessary, compression of the varices with a Blakemore tube.

**Possible Surgical Techniques**

There are several operative approaches for control of variceal hemorrhage in the preschool child. They include transthoracic ligation of the varices, laparotomy and ligation of the varices in the stomach and lower esophagus, endoscopy and direct injection of the varices, or lastly, a procedure successfully used twice at Children's, a proximal gastrectomy and distal esophagectomy with colon interposition.

Prevention of recurrent bleeding until the child is old enough for a shunt is most important in the long-term management of these patients. Most episodes of hemorrhage seem to start after febrile illnesses. These children require bed rest, antacids and cough suppressents. Aspirin, even in very small amounts, will usually result in a recurrence of bleeding and should be avoided.

When the child is over eight years old, a splenoportogram is performed by injecting 25% Hypopaque percutaneously into the spleen prior to doing a portosystemic shunt. This procedure is usually performed in the radiology department just prior to the shunt. In this patient we demonstrated a small portal vein, a large coronary vein draining into gastric and esophageal varices and a splenic vein six millimeters in diameter.

Since many of these patients have an inadequate portal vein, we must do a splenorenal or mesocaval shunt. An adequate splenorenal shunt can be achieved if the splenic vein is greater than one centimeter in diameter. Usually the side of the splenic vein is anastomosed to the side of the left renal vein without spleen removal. There are valuable collateral veins around the spleen which would be destroyed if a splenectomy were performed.

I might mention that some of these children have large spleens with hypersplenism, which subsides six to twelve months after shunting.

The overall results in most series of published cases is a 20% incidence of rebleeding after shunting. In many published series of children with portal hypertension there are some patients who were never shunted. As these nonshunted children get into their teen years, the number of bleeding episodes decreases.

As I stated earlier, this is a difficult disease to treat and our results have not been very good. The patient presented today will probably bleed again and eventually require a shunt. Ligation of the varices serves only to buy time until he gets old enough for an effective portosystemic shunt. ◄


**COOK COUNTY**
**Graduate School of Medicine**

CONTINUING EDUCATION COURSES
STARTING DATES—1978

NEUROLOGY, PART I, BASIC, 5½ days, March 6
ESSENTIALS OF CLINICAL MEDICINE, 5 days, March 6
SPECIALTY REVIEW SURGERY, PART II, March 6
DIAGNOSIS & MANAGEMENT OF PROBLEMS IN GYNECOLOGY. March 6
BASIC EKG, 5 days, March 27
EKG FOR ANESTHESIOLOGISTS, 5 days, March 27
REVIEW COURSE IN PSYCHIATRY, 5 days, April 3
SPECIALTY REVIEW UROLOGY, 5 days, April 10
BASIC SEMINAR & WORKSHOP IN ECHOCARDIOGRAPHY, April 19
SPECIALTY REVIEW PULMONARY DISEASE, 5 days, April 24
STATE & NAT'L. BD. REV. BASIC, April 30, CLINICAL, May 8
ESSENTIALS OF DERMATOLOGY, 5 days, May 1
ADVANCES IN SURGERY, 5 days, May 8
SPECIALTY REVIEW NEPHROLOGY, 5 days, May 8
SPECIALTY REVIEW RHEUMATOLOGY, 5 days, May 8
SPECIALTY REVIEW ANESTHESIOLOGY, 5 days, May 14
SPECIALTY REVIEW OBSTETRICS & GYNECOLOGY, May 15

*Information concerning numerous other continuation courses available upon request.*

**Address:**
**REGISTRAR, 707 South Wood Street,**
**Chicago, Ill. 60612**

# CLASSIFIED ADVERTISING

## POSITIONS & PRACTICE OPPORTUNITIES

**OB-GYN, ENT, PEDIATRICS, SPECIALISTS** needed by 16-man multi-specialty clinic in university community of 50,000 in western Wisconsin; excellent retirement and fringe benefits; fine recreational opportunities; salary negotiable. Send curriculum vitae and references to: John R. Ujda, M.D., La Crosse Clinic, 212 South 11th Street, La Crosse, Wisconsin 54601.

**FULL TIME PHYSICIAN** for Industrial Clinic in Skokie. Surgical experience needed. Salary negotiable. Must have Illinois license. Call (312) 674-4800, Mrs. McCubbin.

**OPPORTUNITIES FOR PHYSICIANS IN INDIANA**—There are several excellent openings among the Indiana State Hospitals at various locations throughout the state for psychiatrists and physicians of other specialties, at most experience levels. A newly-revised salary schedule offers a very competitive income plus a generous package of fringe benefits. An adjunct practice is possible beyond the regular working hours and on-call responsibilities. Please reply with a copy of the c.v. to: Farabee & Associates, Inc., P.O. Box 472, Murray, KY 42071 or call (collect) (502) 753-9772. Farabee is retained by the Indiana Department of Mental Health.

**WANTED**—M.D. to serve as Assistant Medical Director and Assistant Director of Medical Education, 300 bed hospital. 8ox 908 c/o IMJ, 55 E. Monroe, Suite 3510, Chicago, IL 60603.

**PERFECT OPPORTUNITY** to relocate in Los Angeles, California without losing one day's income. Active Family Practice to give to qualified General Practitioner. Monthly net $6,500. Lease my fully equipped, custom built 1800 sq. ft. medical building. Will introduce. Clearence Gazin, M.D., 6711 Melrose Avenue, Los Angeles, Calif. 90038. 213-936-7259.

**EMERGENCY PHYSICIAN, McHENRY:** Full-time career-oriented emergency physician to begin July 1 in 17,000 visit/year emergency department of 140-bed mobile-intensive-care resource hospital and trauma center 50 miles northwest of Chicago. Small town (pop. 8,000). Ski and water sports area. Good back-up from 20-man multi-specialty clinic in adjacent building and from independent specialists in community. Salary and fringes competitive with Chicago area. Send curriculum vitae to: John L. Bowman, M.D., Director, Emergency Services, McHenry Hospital, 3516 W. Waukegan Road, McHenry, IL 60050.

**FAMILY PHYSICIAN OR GENERAL PRACTITIONER** wanted immediately. Predominantly Medicaid practice located on the west side of Chicago. Excellent income. Terms negotiable. Write c/o Box 912, Illinois Medical Journal, 55 E. Monroe, Suite 3510, Chicago, 60603.

**PSYCHIATRIST:** 8oard eligible or board certified with license to practice in Illinois or abiity to obtain same. Full time position with well established community mental health center located in a very attractive area of northwestern Illinois ninety minutes from metropolitan Chicago. Income and fringe benefit package highly competitive and negotiable. Excellent opportunity for the right person who is committed to inter-disciplinary team approach, community mental health models of intervention, and a lifestyle that combines the best of rural living with access to urban stimulation. Psychiatric services would include both outpatient and inpatient components. For additional information, contact Albert E. Graff, Executive Director, Sinnissippi Mental Health Center, Dixon-Sterling Freeway, Dixon, Illinois 61021. Phone collect (815) 284-6611.

**MEDICAL DIRECTOR:** Excellent opportunity for administratively oriented physician. Work in program design at the central office and practice at the new diagnostic and evaluation center. Supervise approximately 50 health care personnel. Excellent state benefits, salary to start in the mid 40's. Send resume to: Dept. of Correctional Services, P.O. Box 94661, Lincoln, Nebraska 68509.
An Equal Opportunity Employer

**EMERGENCY PHYSICIANS NEEDED:** Openings for 3 full-time emergency room physicians for a 450 bed hospital, with 36,000 visits yearly. Location is a large urban area in northern Illinois. The hospital is affiliated with Loyola University. Salary will be based on experience and quality of work. Malpractice and health insurance will be paid. Contact Physicians Emergency Service at 792-3807, 7447 W. Talcott, Suite 314, Chicago, Illinois or Dr. Amito Sircar, Medical Director Emergency Dept., Resurrection Hospital at 774-8000.

**EMERGENCY PHYSICIANS—FULL OR PART TIME:** needed for Danville, Peoria, Streator, Princeton, Monmouth, and Moline, Illinois; compensation to $75,000. Prefer physicians with prior E.R. experience. CPR training is required. Call 800-356-9034 or send C.V. to Central States Emergency Physicians, P.O. 8ox 659, Moline, Illinois, 61265.

**TIRED OF ICE AND SNOW? COME SOUTH!** Need all specialties. Situations available in all southern states. Immediate need for primary care physicians in NC, SC, GA, ALA, MISS, TN. Most are groups providing office, equipment, insurances, retirement program, profit sharing, and other perks. Salaries $50-60K range. OUR FEE IS PAID! Send CV with details to Medical Search, 3274 Buckeye Road, Atlanta, Ga. 30341.

## FOR SALE, LEASE OR RENT

**NORTH SHORE MEDICAL CLINIC,** 5011—5019 N. Sheridan Road, Chicago, Illinois. Completely remodeled—2,800 square feet, nine examination rooms, two private doctor's consultation rooms, one office with examination room reception area, laboratory, x-ray and pharmacy area. Sublet at ($1,900.00) per month including utilities until January 29, 1980.
Options available.
Call Martin Margolis at 499-1400.

**MEDICAL OFFICE SUITE FOR RENT,** Lincoln-8elmont Bldg. 1200 to 1400 sq. ft. available January 1, 1978 in full service, elevator, professional building. Very active long established practice, leaving neighborhood. Call Gary Solomon, 334-5400.

**TO SUBLET—PART TIME—WATER TOWER PLACE:** Ophthalmologist's office, beautifully furnished and equipped—1500 square feet divided into four examining rooms, consultation room, waiting room, secretarial office and mydriatic room. Phone DE 2-4884.

**PRACTICE FOR SALE:** Large one person general practice, in operation 36 years. 8road spectrum of patients, no O8 or pediatrics presently. Office facilities could be developed for group, spacious living accommodations adjoining the office or next door with family oriented recreational facilities (pool, tennis court, enclosed basketball court). Contact: Dr. Kielsmeier's Office, 317 Raymond St., Elgin, Ill. 60120. 312-741-4689.

**MEDICAL CENTER FOR RENT:** Complete and ready to open. 4300 sq. ft. located in active shopping center, 2243-2353 East 95th Street, Chicago. Call Gary Solomon, 334-5400.

## SITUATIONS WANTED

**CONSIDERING STAFF ADDITIONS?** Medical Assistants available throughout the state. Robert Morris College has a Medical Assisting Program accredited by the Council on Medical Education of the American Medical Association in collaboration with the American Association of Medical Assistants. Our Medical Assistants are proficient in administrative, clinical, and laboratory areas. Graduates are prescreened prior to application. No fee charged to Employer or Applicant. Call: Toll Free 800-252-9151 or (217) 357-2121; Robert Morris College Placement Center, College Avenue, Carthage, IL 62321.

**PHYSICIAN'S ASSISTANT,** 8A, MA, 31, graduate of accredited program, Board eligible, work experience in group practice in major medical center. Relocating. Desires position in Chicago or Northern Illinois. Contact M. J. Van Hook, 1925 Keeney Street, Evanston, Illinois 60202.

**EXPERIENCED ER PHYSICIAN** wants to join emergency room hospital group in permanent ER position. Please write 8ox 910, c/o IMJ, 55 E. Monroe, Suite 3510, Chicago, 60603.

**RADIOLOGIST** seeks permanent part-time position, 4 hrs/day, fluroscopy and/or film reading. Chicago metropolitan area. Please write 8ox 911, c/o IMJ, 55 E. Monroe, Suite 3510, Chicago, IL 60603.

## MISCELLANEOUS

**HARNESS RACE HORSE:** Selling partnership in 8. S. Skipper p.2, 158.1. 2 yr. old Sportsman's Park record holder. For details call Rudy Gurrola 682-0121 or 279-8720.

## GUARANTY FUND CERTIFICATE

**FOR SALE:** Guaranty Fund Certificate #5448, Territory II, Original Class 3, GP and Surgery. Original Cost $2,476.00. Call: Dr. William E. Mundl, 217-762-2108 or 217-762-2284.

**ILLINOIS STATE MEDICAL INTER-INSURANCE EXCHANGE GUARANTY FUND CERTIFICATE.** For sale due to retirement. Principal amount $724. Asking price $500. Contact Paul R. Linden, M.D., 719-16th Street, Moline or 309-764-6705.

**GUARANTY FUND CERTIFICATE.** ISMIS Exchange #7761. Orig. cost $960.00, Class II 100-300,000 for sale. Please call: (312) 654-8447.

*IMJ and ISMS are not acting as brokers or agents; this is provided as a membership service.*

## *President's Page*



# Regulation and Economic Reality

For many years, government critics charged that regulatory agencies were "captives" of the groups they were supposed to regulate. It now appears that the consumer movement has swung the pendulum in the opposite direction.

Labor unions and other special interest groups have encouraged regulatory bodies to expand the scope of their jurisdictions. Government bureaucrats now grapple with social issues such as the quality of life and redistribution of income, but ignore the economic consequences of their actions.

This new philosophy of regulation is particularly visible in the health care field. Social concerns have been addressed by increases in the minimum wage and other regulatory changes. However, little consideration has been given to the effect these actions have on the cost of medical care.

Patients must be informed of the impact of government overregulation. Congress and the General Assembly must be alerted to the need for cost-benefit analysis prior to any new regulatory program. The public and government must deal with economic reality.

George T. Wilkins, Jr., M.D.

# Doctor's News

**DRUG ABUSE CONFERENCE SCHEDULED** – The AMA Department of Mental Health will sponsor "The Physician and Drug Abuse Treatment," a two-day conference to study major aspects of the drug abuse problem and its treatment on March 31 and April 1, 1978 at the Water Tower Hyatt Hotel in Chicago. Former ISMS president Joseph Skom, M.D., will chair the meeting, which will include workshops and clinical seminars.

Referrals, law enforcement relations, prescribing practices, office-based treatment and the special aspects of adolescent care and geriatric problems are among scheduled topics. Complications in the emergency room and perinatal care will be addressed in two workshops on the first day. That evening, informal discussion groups will consider alternative treatments, including therapeutic communities, self-help groups, methadone maintenance, industrial programs and impaired physician programs.

On Saturday, April 1, the workshops will consider psychiatry and drug abuse and the complications for surgical patients who have abused controlled substances. At the meeting's conclusion, the conference hopes to make recommendations for local level work and projects with single state agencies.

The meeting carries hour-for-hour AMA Category I CME credit. AMA members, medical society executives and non-physicians may attend at a cost of $50. Non-member physicians may register for $100, and special reduced rates for housestaff and medical students are available.

For further information, contact the American Medical Association, 535 N. Dearborn Street, Chicago, 60610.

**GOVERNMENT DECIDES DOCTORS COUNT**—Incorporated Illinois physicians are included for the first time this year in U.S. Census Bureau questionnaires on business activities of their corporations. The questionnaires now being received are extensive, and, by law, must be completed. (Professionals were formerly exempted from this requirement).

**HEMO POLICY CHANGE**—The Missouri-Illinois Regional Red Cross Blood Program medical advisory committee recently discontinued therapeutic phlebotomy. In explaining the decision, Director William V. Miller, M.D., said that Federal regulations requiring diagnostic labels on all blood units from phlebotomy donors promoted their disuse. Also, it was felt that an increasing number of these patient/donors might require emergency care beyond the capabilities of a blood center or mobile site.

To minimize inconvenience, the Red Cross will provide, at suitable cost, collection bags for physicians desiring to perform therapeutic phlebotomy in their offices. They may also arrange for personnel instruction from physician offices or participating hospitals in phlebotomy technique.

**FDA REVOKES FIBRINOGEN LICENSES**—All licenses for the sale, barter or exchange of fibrinogen (human) by any manufacturer were voided as of December 7, 1977. The Food and Drug Administration announced that their action was taken at the request of the licensed manufacturers because its effectiveness is questionable, and the substance carries a higher risk of hepatitis transmission than available substitutes. Fibrinogen already sold and delivered as of that date may not be resold, bartered or exchanged by owners or custodians after July 1, 1978.

**BIOAVAILABILITY SEMINAR SCHEDULED**—The Northwestern University Medical School Department of Continuing Medical Education, with support from Ciba-Geigy Pharmaceuticals, will sponsor a day-long program featuring speakers from American medical schools, experts in pharmacology, and representatives of the legal profession and Food and Drug Administration on April 15, 1978, at the Drake Hotel in Chicago. "Bioavailability Problems for Physicians and Pharmacists," will feature speakers providing background information on such practical factors as the pharmacokinetics of bioavailability, drug product selection, the biopharmaceutic basis of the MAC program and legal aspects of generic substitution.

The symposium has been authorized for Category I CME credit. Fee for attendance is $20.00. For further information, please contact James Dyson, Ph.D., Director of Medical Education, Northwestern University Medical School, Center for Continuing Education, 303 E. Chicago Avenue, Chicago 60611.

**ILLINOIS PSYCHIATRIC SOCIETY ANNUAL DINNER ANNOUNCED**—Jerome S. Beigler, M.D., president, and Brenda Solomon, M.D., program chair, have announced that the 1978 IPS Annual Dinner is scheduled for Wednesday, March 29, 1978, at the Drake Hotel in Chicago.

Paul H. Ornstein, M.D., a professor of psychiatry from the University of Cincinnati and training and supervising analyst at the Cincinnati Psychoanalytic Institute, will be the keynote speaker. His discussion will address "The Impact of the Psychology of the Self on the Conduct of Psychotherapy."

Reservations are required for the event. Please contact Wendy J. Smith at the IPS offices (312/782-1654) for additional information.

**PHYSICIANS IN THE NEWS**—**Andrew L. Carney, M.D.,** Oak Park, was recently awarded the Golden Eagle, the highest possible achievement in educational filmmaking. Doctor Carney received the honor for "Vertebral Artery Surgery," which is the first film ever made on that subject. Doctor Carney is an assistant professor of surgery at the Abraham Lincoln School of Medicine and also the UI College of Medicine in Chicago. . . . **Joseph A. Wells, M.D., Ph.D.,** Oak Park, will retire July 1, 1978, as dean of the Loyola University Stritch School of Medicine. Doctor Wells, former associate dean at the Northwestern University School of Medicine, was appointed dean at Loyola in 1970. His tenure is credited with institution of a regular three-year degree program at Stritch, as well as a special track curriculum for selected students. . . . Augustana Hospital and Health Care Center in Chicago has announced the results of recent medical staff elections. **Frank S. Caporale, M.D.,** attending staff physician in the department of surgery, was elected to a two year term as medical staff president, **Harry Kalsch, M.D.,** newly chosen medical staff vice president, is a member of the ISMS House of Delegates. **Doctor Mario Simeran,** attending staff physician in family practice, was elected medical staff secretary. . . . The Radiological Society of North America recently elected Chicago physician **William Meszaros** as their new president-elect.

**Franklin D. Yoder, M.D.,** director of Colorado's Weld County Health Department, was recently elected chairman of the AMA-American Board of Preventive Medicine Residency Review Committee. The Committee reviews applications for approval of preventive medicine residencies, which includes aero-space, occupational, general preventive and public health medicine.

# If you're rethinking your choice of tranquilizers, here are

# four good reasons to make it

# Tranxene® CLORAZEPATE DIPOTASSIUM

C IV

4306CB

1. Tranxene has been shown equivalent to diazepam in anti-anxiety effectiveness in controlled studies with hundreds of patients.

2. Tranxene is remarkably well tolerated; excessive sedation is seldom a problem.

3. Tranxene offers oral dosing options unmatched by another tranquilizer – not only conventional divided dose forms, but also economical single dose tablets for once-a-day use at any convenient hour.

4. Tranxene is physically different in form and appearance from other widely used agents. (Fewer patients will know or recognize it.)

ABBOTT

Please see overleaf for prescribing information.



# Tranxene® CIV
(CLORAZEPATE DIPOTASSIUM) 4306CB

CAPSULES,
SINGLE DOSE TABLETS
**Brief Summary**

ABBOTT

**ACTIONS** — Pharmacologically, clorazepate dipotassium has the characteristics of the benzodiazepines. It has depressant effects on the central nervous system. The primary metabolite, nordiazepam, quickly appears in the blood stream. The serum half-life is about 2 days. The drug is metabolized in the liver and excreted primarily in the urine. (See ANIMAL AND CLINICAL PHARMACOLOGY section.)

**INDICATIONS** — TRANXENE is indicated for the symptomatic relief of anxiety associated with anxiety neurosis, in other psychoneuroses in which anxiety symptoms are prominent features, and as an adjunct in disease states in which anxiety is manifested.

TRANXENE is indicated for the symptomatic relief of acute alcohol withdrawal.

The effectiveness of TRANXENE in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should reassess periodically the usefulness of the drug for the individual patient.

**CONTRAINDICATIONS** — TRANXENE is contraindicated in patients with a known hypersensitivity to the drug, and in those with acute narrow angle glaucoma.

**WARNINGS** — TRANXENE is not recommended for use in depressive neuroses or in psychotic reactions.

Patients on TRANXENE should be cautioned against engaging in hazardous occupations requiring mental alertness, such as operating dangerous machinery including motor vehicles.

Since TRANXENE has a central nervous system depressant effect, patients should be advised against the simultaneous use of other CNS-depressant drugs, and cautioned that the effects of alcohol may be increased.

Because of the lack of sufficient clinical experience, TRANXENE is not recommended for use in patients less than 18 years of age.

*Physical and Psychological Dependence:*

Withdrawal symptoms (similar in character to those noted with barbiturates and alcohol) have occurred following abrupt discontinuance of clorazepate. Symptoms of nervousness, insomnia, irritability, diarrhea, muscle aches and memory impairment have followed abrupt withdrawal after long-term use of high dosage.

Caution should be observed in patients who are considered to have a psychological potential for drug dependence.

Evidence of drug dependence has been observed in dogs and rabbits which was characterized by convulsive seizures when the drug was abruptly withdrawn or the dose was reduced; the syndrome in dogs could be abolished by administration of clorazepate.

*Usage in Pregnancy:*

**An increased risk of congenital malformations associated with the use of minor tranquilizers (chlordiazepoxide, diazepam, and meprobamate) during the first trimester of pregnancy has been suggested in several studies. TRANXENE, a benzodiazepine derivative, has not been studied adequately to determine whether it, too, may be associated with an increased risk of fetal abnormality. Because use of these drugs is rarely a matter of urgency, their use during this period should almost always be avoided. The possibility that a woman of childbearing potential may be pregnant at the time of institution of therapy should be considered. Patients should be advised that if they become pregnant during therapy or intend to become pregnant they should communicate with their physician about the desirability of discontinuing the drug.**

*Usage during Lactation:*

TRANXENE should not be given to nursing mothers since it has been reported that nordiazepam is excreted in human breast milk.

**PRECAUTIONS** — In those patients in which a degree of depression accompanies the anxiety, suicidal tendencies may be present and protective measures may be required. The least amount of drug that is feasible should be available to the patient.

Patients on TRANXENE for prolonged periods should have blood counts and liver function tests periodically. The usual precautions in treating patients with impaired renal or hepatic function should also be observed.

In elderly or debilitated patients, the initial dose should be small, and increments should be made gradually, in accordance with the response of the patient, to preclude ataxia or excessive sedation.

**ADVERSE REACTIONS** — The side effect most frequently reported was drowsiness. Less commonly reported (in descending order of occurrence) were: dizziness, various gastrointestinal complaints, nervousness, blurred vision, dry mouth, headache, and mental confusion. Other side effects included insomnia, transient skin rashes, fatigue, ataxia, genitourinary complaints, irritability, diplopia, depression and slurred speech.

There have been reports of abnormal liver and kidney function tests and of decrease in hematocrit.

Decrease in systolic blood pressure has been observed.

**DOSAGE AND ADMINISTRATION**

*For the symptomatic relief of anxiety:*

TRANXENE is administered orally. The capsules may be given in divided doses. The usual daily dose is 30 mg. The dose should be adjusted gradually within the range of 15 to 60 mg. daily in accordance with the response of the patient. In elderly or debilitated patients it is advisable to initiate treatment at a daily dose of 7.5 to 15 mg.

TRANXENE capsules may also be administered as a single dose daily at bedtime; the recommended initial dose is 15 mg. After the initial dose, the response of the patient may require adjustment of subsequent dosage. Lower doses may be indicated in the elderly patient. Drowsiness may occur at the initiation of treatment and with dosage increment.

TRANXENE-SD tablets (22.5 mg.) may be administered as a single dose every 24 hours. This tablet is intended as an alternate dosage form for the convenience of patients stabilized on a dose of 7.5 mg. capsules three times a day. TRANXENE-SD tablets should not be used to initiate therapy

TRANXENE-SD HALF STRENGTH tablets (11.25 mg.) may be administered as a single dose every 24 hours.

*For the symptomatic relief of acute alcohol withdrawal:*

Recommended schedule: 1st 24 hours, 30 mg. TRANXENE initially, followed by 30 to 60 mg. in divided doses; 2nd 24 hours, 45 to 90 mg. in divided doses; 3rd 24 hours, 22.5 to 45 mg. in divided doses; 4th day, 15 to 30 mg. in divided doses. Thereafter gradually reduce to 7.5 to 15 mg. daily, and discontinue as soon as condition is stable. Maximum daily dose is 90 mg. Avoid excessive reductions in total drug on successive days.

**DRUG INTERACTIONS** — If TRANXENE is to be combined with other drugs acting on the central nervous system, careful consideration should be given to the pharmacology of the agents to be employed. Animal experience indicates that TRANXENE prolongs the sleeping time after hexobarbital or after ethyl alcohol, increases the inhibitory effects of chlorpromazine, but does not exhibit monoamine oxidase inhibition. Clinical studies have shown increased sedation with concurrent hypnotic medications. The actions of the benzodiazepines may be potentiated by barbiturates, narcotics, phenothiazines, monoamine oxidase inhibitors or other antidepressants.

If TRANXENE is used to treat anxiety associated with somatic disease states, careful attention must be paid to possible drug interaction with concomitant medication.

**MANAGEMENT OF OVERDOSAGE** — Overdosage is usually manifested by varying degrees of CNS depression ranging from slight sedation to coma. As in the management of overdosage with any drug, it should be borne in mind that multiple agents may have been taken.

There are no specific antidotes for the benzodiazepines. The treatment of overdosage should consist of the general measures employed in the management of overdosage of any CNS depressant. Gastric evacuation either by the induction of emesis, lavage, or both, should be performed immediately. General supportive care, including frequent monitoring of the vital signs and close observation of the patient, is indicated. Hypotension, though rarely reported, may occur with large overdoses. In such cases the use of agents such as Levophed® (levarterenol) or Aramine® (metaraminol) should be considered.

While reports indicate that individuals have survived overdoses of TRANXENE (clorazepate dipotassium) as high as 450 to 675 mg., these doses are not necessarily an accurate indication of the amount of drug absorbed since the time interval between ingestion and the institution of treatment was not always known. Sedation in varying degrees was the most common physiological manifestation of TRANXENE overdosage. Deep coma when it occurred was usually associated with the ingestion of other drugs in addition to TRANXENE.

**CLINICAL PHARMACOLOGY** — Studies in healthy men have shown that TRANXENE has depressant effects on the central nervous system. Prolonged administration of single daily doses as high as 120 mg. was without toxic effects. Abrupt cessation of high doses was followed in some patients by nervousness, insomnia, irritability, diarrhea, muscle aches, or memory impairment.

*Absorption – Excretion:*

After oral administration of TRANXENE, there is essentially no circulating parent drug. Nordiazepam, its primary metabolite, quickly appears in the blood stream. In 2 volunteers given 15 mg. (50 $\mu$C) of $^{14}$C-TRANXENE, about 80% was recovered in the urine and feces within 10 days. Excretion was primarily in the urine with about 1% excreted per day on day 10.

**HOW SUPPLIED** — TRANXENE (clorazepate dipotassium) is supplied as capsules in three dosage strengths:

3.75 mg. capsules (gray with white cap) in bottles of 100 (NOC 0074-3417-13) and 500 (NOC 0074-3417-53). Also available in ABBO-PAC® unit dose packages of 100 capsules (NOC 0074-3417-11).

7.5 mg. capsules (gray with maroon cap) in bottles of 30 (NOC 0074-3418-30), 100 (NDC 0074-3418-13) and 500 (NOC 0074-3418-53). Also available in ABBO-PAC unit dose packages of 100 capsules (NOC 0074-3418-11).

15 mg. capsules (all gray) in bottles of 100 (NOC 0074-3419-13) and 500 (NOC 0074-3419-53). Also available in ABBO-PAC unit dose packages of 100 capsules (NOC 0074-3419-11).

TRANXENE-SD single dose tablets are supplied in two dosage strengths:

TRANXENE-SD 22.5 mg. tablets (tan-colored) in bottles of 100 (NOC 0074-2997-13).

TRANXENE-SD HALF STRENGTH 11.25 mg. tablets (blue-colored) in bottles of 30 (NOC 0074-2699-30) and 100 (NOC 0074-2699-13).

7113213R



# *EKG*

*(Continued from page 92)*

**Answers: 1. C.D. 2. C.**

The ECG shows a sinus tachycardia and a current of injury compatible with acute pericarditis. There is baseline wandering related to respiratory movements. The ST elevation can best be seen in leads I, II, AVF, V5, and V6. The ST vector is pointing to the area of pericarditis and is usually located anteriorly, inferiorly, and to the left. In any case of pericarditis, pericardial tamponade is a consideration. A chest X-ray is helpful but it takes approximately 250 cc or more in the pericardium before the cardiac silhouette enlarges. The echocardiogram is the recommended technique for searching out pericardial effusion.

Repeat physical exams with attention to the neck veins and pulses paradoxus are critical. There are many etiologies for pericarditis. The prognosis in any individual patient is related to the basic disease process rather than the pericarditis, eg., the extent of myocardial infarction, the degree of renal failure. Our patient seemed to have a viral pericarditis but the virus was not isolated. The most common cause of pericarditis is that termed idiopathic and this may relate to the difficulty of virus isolation. Our patient recovered uneventfully with only symptomatic care. For an extensive review of this topic, see A. Davis: "Cardiovascular Clinics," in Pericardial Diseases, D. H. Spodick, *ed.*, Philadelphia, PA, 1976.

**Introductory Lectures and Demonstrations**

**NASAL BREATHING TESTS**

*An Aid in Physical Diagnosis of Difficulty of Breathing and Other Systemic Disturbances*

*Wednesdays, May 10 and May 17, 1978. 9-12 a.m.*
*Approved for 6 hours credit. Category I*

A. Nasal breathing pressure determinations.

B. Flow/pressure evaluation of airway resistance (or conductance).

C. Nasa/pulmonary function tests.

D. Nasa/antral pressure studies.

Clinically, these tests are used by the family practitioner and the specialist 1) for the diagnosis of functional disturbances of the nose and antra (maxillary sinuses), 2) for possible indications of systemic derangement, such as those involving the heart and lung, 3) as part of complete routine general physical "check ups," 4) evaluation of effects of nasal surgical and/or medical treatment on nasal function problems.

Simple mechanical apparatus and sophisticated electronic equipment are now commonly used.

Shown in scientific exhibits at American Medical Association annual meetings (1959, 1975 "Honor Award," 1976) and at American Academy of Ophthalmology and Otolaryngology 1975. American Rhinologic Society 1975, 1976, and 1977.

Specially designed for the general practitioner and as an orientation for the specialist.

Write:
ILLINOIS MASONIC MEDICAL CENTER, Maurice H. Cottle, M.D.
Rhinology and Rhinomanometry, 836 Wellington Avenue, Chicago, Illinois 60657.

Books, reprints, and mechanical apparatus available to course participants. Agenda for course sessions on request.

*With the Cooperation of The American Rhinologic Society*

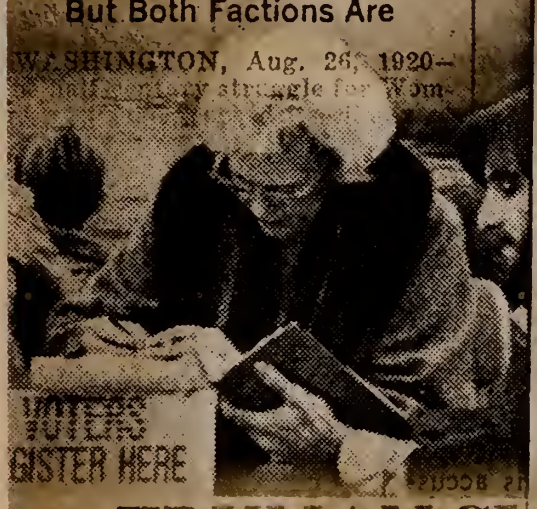
# COLBY PROCLAIMS WOMAN SUFFRAGE

Signs Certificate of Ratification at His Home Without Women Witnesses.

MILITANTS VEXED AT PRIVACY.

Wanted Movies of Ceremony, But Both Factions Are

WASHINGTON, Aug. 26, 1920—




# Social Security Bill Is Signed; Gives Pensions to Aged, Jobl

## Roosevelt Approves Message Intended to Benefit 30,00 Persons When States Adopt Cooperating Laws–He C the Measure 'Cornerstone' of His Economic Progra

WASHINGTON, Aug. 14, The Social Security Bill, pr a broad program of unempl insurance and old age pe and counted upon to benef 20,000,000 persons, became day when it was signed by dent Roosevelt in the pres those chiefly responsible f ting it through Co[illegible]s.

Mr. Roosevelt cal[illegible] "the cor[illegible]erstone which is [illegible]eing [illegible] me[illegible]s c[illegible]pl[illegible]

CO

# SENATE APPROVES 18-YEAR OLD VOTE IN ALL ELECTIONS

Amendment to Constitution is Sent to House, Where Passage is Expected

WASHINGTON, March 10, 1971—The Senate approved today, 94 to 0, and sen[illegible]

# OL IGNI the Draf Ends No



WASHINGTON, Jan. 27, 1973—"With the signing of the peace agreement in Paris today, and after receiving a report from the

# TRUMAN CLOSES TED NATIONS CONFEREN TH PLEA TO TRANSLATE CHARTER INTO DEEDS

## NEW WORLD HOPE

President Hails 'Great Instrument of Peace,' Insists It Be Used

## HISTORIC LANDMARK

Meeting Gives Standing Ovation as Executive Pictures Peace Gain

"If we fail to use it," he declared to the solemn final meeting of the delegates, 'we shall betray all of those who have died in order that we might meet here in freedom and safety to create it.'

"If we seek to use it selfishly—for the advantage of any one nation or any small group of nations—we shall be equally guilty of that betrayal."

Fervent Interpolation

The President, speaking in the auditorium of the War Memorial Opera House, built in memory of sons of the Golden Gate city who gave their lives in the first World War, in which he himself served, seemed to give unconscious expression to the solemn feeling of the occasion when, at the outset of his speech, he interpolated the words, half a hope, half a prayer:

"Oh, what a great day this can be in history!"

Just before the plenary session

# PATIENT PACKAGE INSERTS: A CONCEPT WHOSE TIME HAS COME?

*The consumer's right to know is an irreversible and desirable trend of the Seventies. It extends, and properly, to a patient's right to know more about his or her prescription medications. One way, gaining favor, is through patient package inserts. Wisely-prepared and properly distributed when medically indicated, they could markedly improve patient knowledge and drug therapy—laudable goals by anyone's standards.*

*The PMA endorses these goals and will work with government, the health professions and consumers to achieve them.*

## The Advantages

The concept holds promise of benefits: better patient understanding of the product prescribed, better adherence to the treatment plan, and more awareness of possible side reactions.

Every doctor has had patients who fail to finish antibiotic regimens because they feel better. Some patients assume that if one tranquilizer or analgesic is good, two may be twice as good. Still others fail to report dizziness while on antihypertensive therapy —and so on.

Problems like these might arise less often if the patient received written information in addition to verbal instructions. Some studies suggest that patients are more receptive to such materials, and they more often understand the verbal instructions and follow them, when inserts are used.

## The Disadvantages

There are also some potential problems. Obviously, the inserts must be clearly phrased, without extraneous or complex detail. How much information is enough? How can it be kept current? Should all patients receive the same information? Should inserts be included with all drugs? Should only potential problems be listed or are patients better off with a "fair balance" presentation that describes usefulness as well as drawbacks?

These and similar questions require answers, since model inserts have yet to be properly developed and tested. Despite the need for these studies, the FDA is proceeding prematurely with inserts on selected products. We think the Congress is the only place where the matter can be given the proper legal status and direction, particularly since it represents a conceptual change in the legal, medical and social framework of the nation's prescription drug information system.

## The Solution

The PMA believes that carefully-devised pilot studies of various kinds of inserts are needed. They should be developed and implemented with full participation by doctors, pharmacists, consumers, communications experts and the drug industry. Such studies will provide reliable pathways to follow, so that inserts will be useful aids to medical practice.

And particularly we think that you should be closely involved in this debate and in these studies and decisions. Otherwise, people with less experience and qualifications may control the purposes, content and use of a tool with considerable promise for improved patient care. It could make a difference in your practice tomorrow, and more importantly, in the health of your patients.

PMA
THE PHARMACEUTICAL MANUFACTURERS ASSOCIATION
1155 FIFTEENTH ST., N. W., WASHINGTON, D. C. 20005

# A New Vision of Catapres® (clonidine HCl)

# 20/20



## The first 20 days

- Catapres lowers blood pressure promptly.
- No contraindications.
- Some patients may have dry mouth, drowsiness, and sedation. Tell them that these tend to diminish with continued use.
- Giving the larger part of the divided dose at bedtime can help alleviate drowsiness and sedation.

## The next 20 years*

- Lowered blood pressure.
- Little impotence, depression or postural hypotension.
- No fatal hepatotoxicity in over a decade of worldwide use.
- Broad therapeutic dosage range to keep step with changing dosage needs over the years.

*Tolerance may develop in some patients, necessitating a reevaluation of therapy.

For full details on adverse reactions, warnings, and precautions, see brief summary of the prescribing information on last page of this advertisement.



**Catapres**® **(clonidine HCl)**
**For Step 2 in Hypertension**

HYPERTENSION

# A New Vision of Catapres® (clonidine HCl)

Tablets of 0.1 and 0.2 mg




## What you do the first 20 days Can help him the next 20 years

**Catapres®**
**(clonidine hydrochloride)**
Tablets of 0.1 mg and 0.2 mg

**Indication:** The drug is indicated in the treatmer hypertension. As an antihypertensive drug, Cata (clonidine hydrochloride) is mild to moderate in It may be employed in a general treatment progr with a diuretic and/or other antihypertensive age as needed for proper patient response.

**Warnings:** Tolerance may develop in some patie necessitating a reevaluation of therapy.
*Usage in Pregnancy:* In view of embryotoxic find animals, and since information on possible adve effects in pregnant women is limited to uncontr clinical data, the drug is not recommended in w who are or may become pregnant unless the pot benefits outweigh the potential risk to mother a
*Usage in Children:* No clinical experience is ava with the use of Catapres (clonidine hydrochlorid children.

**Precautions:** When discontinuing Catapres (clo hydrochloride), reduce the dose gradually over 2 4 days to avoid a possible rapid rise in blood pr and associated subjective symptoms such as ne ness, agitation, and headache. Patients should instructed not to discontinue therapy without co their physician. Rare instances of hypertensive lopathy and death have been recorded after ces of clonidine hydrochloride therapy. A causal rel ship has not been established in these cases. I been demonstrated that an excessive rise in blo sure, should it occur, can be reversed by resum of clonidine hydrochloride therapy or by intrave nous phentolamine. Patients who engage in pot tially hazardous activities, such as operating m or driving, should be advised of the sedative ef This drug may enhance the CNS-depressive eff alcohol, barbiturates and other sedatives. Like agent lowering blood pressure, clonidine hydrc should be used with caution in patients with se coronary insufficiency, recent myocardial infarc cerebrovascular disease or chronic renal failure

As an integral part of their overall long-term patients treated with Catapres (clonidine hydrc should receive periodic eye examinations. Whil except for some dryness of the eyes, no drug-r abnormal ophthalmologic findings have been r with Catapres (clonidine hydrochloride), in sev studies the drug produced a dose-dependent i in the incidence and severity of spontaneously ring retinal degeneration in albino rats treated 6 months or longer.

**Adverse Reactions:** The most common reactio dry mouth, drowsiness and sedation. Constipa dizziness, headache, and fatigue have been re Generally these effects tend to diminish with c therapy. The following reactions have been ass with the drug, some of them rarely. (In some ir an exact causal relationship has not been esta These include: Anorexia, malaise, nausea, von parotid pain, mild transient abnormalities in li tion tests; one report of possible drug-induce titis without icterus and hyperbilirubinemia in receiving clonidine hydrochloride, chlorthalid papaverine hydrochloride. Weight gain, transi tion of blood glucose, or serum creatine phos congestive heart failure, Raynaud's phenome dreams or nightmares, insomnia, other behavi changes, nervousness, restlessness, anxiety a depression. Also rash, angioneurotic edema, l urticaria, thinning of the hair, pruritus not ass with a rash, impotence, urinary retention, inci sensitivity to alcohol, dryness, itching or burn eyes, dryness of the nasal mucosa, pallor, gyn mastia, weakly positive Coombs' test, asympt electrocardiographic abnormalities manifeste Wenckebach period or ventricular trigeminy.

**Overdosage:** Profound hypotension, weaknes lence, diminished or absent reflexes and vom lowed the accidental ingestion of Catapres (c hydrochloride) by several children from 19 mo 5 years of age. Gastric lavage and administra analeptic and vasopressor led to complete re within 24 hours. Tolazoline in intravenous dos 10 mg at 30-minute intervals usually abolishe fects of Catapres (clonidine hydrochloride) o

**How Supplied:** Catapres, brand of clonidine l chloride, is available as 0.1 mg (tan) and 0.2 (orange) oval, single-scored tablets in bottles and 1000.

For complete details, please see full presc information.

Under license from Boehringer Ingelheim

Boehringer Ingelheim Ltd.
Ridgefield, CT. 06877

# *Viewbox*

*(Continued from page 99)*



**DIAGNOSIS: Lymphangtic spread of metastatic cancer from a carcinoma of the splenic flexure.**

Figure 2 demonstrates a filling defect in the air column of the splenic flexure, confirmed on barium enema. (Figure 3 shown at right) A lung biopsy revealed a typical microscopic pattern of tumor in the lymphatics which invaded septal connective tissue. This patient did not demonstrate hilar adenopthy. However, massive mediastinal lymph node involvement is not a necessary prerequisite for lymphatic spread of tumor in the lungs. An attractive hypothesis is that tumor usually reaches the lung by vascular spread with embolization into small peripheral vessels which then break through into the lymphatics as the path of least resistance. Usually the primary source of lymphangtic spread are adenocarcinomas of the breast, but numerous other primary sites are listed in the literature.


# DEPARTMENT CHAIRMAN OF MEDICINE

The Ravenswood Hospital Medical Center, located at 4550 N. Winchester Ave., Chicago, Illinois, a teaching/community 450 bed hospital, is seeking a Department Chairman of Medicine. The Hospital is affiliated with the Abraham Lincoln School of Medicine of the University of Illinois, and has an approved internal medicine residency program and an approved continuing medical education program.

The individual for this position must be board certified in his/her area of specialty by education, or qualified with demonstrated competency in this area of specialty; and shall also have demonstrated professional and administrative abilities and possess a knowledge of education techniques. The individual must have a firm commitment to medical education, as well as to quality medical care, and shall be administratively responsible for the Department of Medicine.

The Medical Center offers a competitive salary and benefit program. Qualified applicants please submit resumes in confidence to:

**Maurice A. Colbert, M.D.**
**RAVENSWOOD HOSPITAL MEDICAL CENTER**
**4550 N. Winchester Ave.**
**Chicago, Illinois 60640**
**(312) 878-4300, ext. 342**
*An Equal Opportunity Employer*

IMJ
Illinois Medical Journal

# YOUR ADVERTISERS

*Our advertisers serve the Medical Profession and support your Journal. All advertisers are approved by your Journal Committee. It will help you and your society to mention your Journal when writing them.*

## Space Representatives

United Media Associates, Inc., 16 Bruce Park Avenue, Greenwich, Conn. 06830

## Pharmaceuticals


161-162 **Abbott Laboratories**
*Tranxene*

166-168 **Boehringer Ingelheim**
*Catapres*

100-101 **Burroughs Wellcome Co.**
*Cardilate*

Cover 2 **Burroughs Wellcome Co.**
*Neosporin*

107-108 **Geigy Pharmaceuticals**
**Div. of Ciba-Geigy Corp.**
*Tofranil—P.M.*

110 **Eli Lilly and Company**
*Kefzol*

139-142 **Mead Johnson Laboratories**
*Colace*
*Vasodilan*
*Quibron*

89-90 **Roche Laboratories**
**Div. of Hoffman-LaRoche**
*Librax*

Covers 3&4 **Roche Laboratories**
**Div. of Hoffman-LaRoche**
*Librium*

96 **Smith Kline and French Laboratories**
**Div. of SmithKline Corp.**
*Dyazide*

94-95 **Warren-Teed Laboratories**
*Kaon Elixir and Tabs*

91 **Warren-Teed Laboratories**
*Modane*


## Insurance


116 **Medical Protective Co.**
*Professional Liability Ins.*

124 **Parker Aleshire and Co.**
*Group Insurance*


## Services and Continuing Education


97-98 **Blue Cross/Blue Shield Report**

157 **Classified Advertising**

137 **Clover Leaf Towers**
*Office Space*

156 **Cook County Graduate School**
*Continuing Medical Education*

106 **Illinois Hospital Association**
*Management Guidebook*

163 **Illinois Masonic Medical Center**
*Continuing Medical Education*

146 **ISMS Guide to Continuing Medical Education**

103 **Medical World News**

120 **O'Hare International Autos**
*Leasing Service*

105 **Park West Medical Plaza**
*Office Space*

164-165 **Pharmaceutical Manufacturers' Association**
*Patient Package Inserts*

169 **Ravenswood Hospital Medical Center**
*Departmental Chairman Needed*

102 **Rush Presbyterian-St. Luke's Hospital**
*Continuing Medical Education*

135 **South Carolina Medical Association**
*Practice Opportunities*

153 **U.S. Army**
*Recruitment*

# THE ANXIETY-SPECIFIC.

- a predictable pattern of patient response
- seldom associated with serious side effects, in proper dosage
- rarely interferes with mental acuity
- used concomitantly with many primary medications
- three dosage strengths meet most patient needs

## LIBRIUM® Ⓒℳ
## chlordiazepoxide HCl/Roche
### 5mg, 10mg, 25mg capsules

Libritabs® (chlordiazepoxide) available in 5 mg, 10 mg and 25 mg tablets.




**prescribing, please consult com-**
**roduct information, a summary of**
**follows:**
**ions:** Relief of anxiety and tension
ng alone or accompanying various
e states.
**indications:** Patients with known
ensitivity to the drug.
**ngs:** Warn patients that mental and/
ical abilities required for tasks
driving or operating machinery
impaired, as may be mental alert-
children, and that concomitant
h alcohol or CNS depressants may
n additive effect. Though physical
ychological dependence have rare-
reported on recommended doses,
ution in administering to addiction-
ndividuals or those who might in-
dosage; withdrawal symptoms
ding convulsions), following discon-
on of the drug and similar to those
ith barbiturates, have been reported.

**ge *in Pregnancy:* Use of minor**
**quilizers during first trimester**
**uld almost always be avoided**
**ause of increased risk of con-**
**ital malformations as suggested**
**everal studies. Consider possi-**
**y of pregnancy when instituting**
**rapy; advise patients to discuss**
**rapy if they intend to or do**
**ome pregnant.**

**utions:** In the elderly and debilitated,
children over six, limit to smallest
ve dosage (initially 10 mg or less per
o preclude ataxia or oversedation,
sing gradually as needed and toler-
Not recommended in children under
ough generally not recommended, if
nation therapy with other psycho-
s seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

**Adverse Reactions:** Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

**Usual Daily Dosage:** Individualize for maximum beneficial effects. *Oral—Adults:* Mild and moderate anxiety and tension, 5 or 10 mg *t.i.d.* or *q.i.d.*; severe states, 20 or 25 mg *t.i.d.* or *q.i.d. Geriatric patients:* 5 mg *b.i.d.* to *q.i.d.* (See Precautions.)

**Supplied:** Librium® (chlordiazepoxide HCl) *Capsules*, 5 mg, 10 mg and 25 mg—bottles of 100 and 500; Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10; Prescription Paks of 50, available singly and in trays of 10. Libritabs® (chlordiazepoxide) *Tablets*, 5 mg, 10 mg and 25 mg—bottles of 100 and 500. With respect to clinical activity, capsules and tablets are indistinguishable.

ROCHE Roche Products Inc.
Manati, Puerto Rico

Please see following page.

# THE ANXIETY-SPECIFIC.

Since its discovery in the research laboratories at Roche, Librium has been the object of ongoing pharmacologic and clinical investigation.

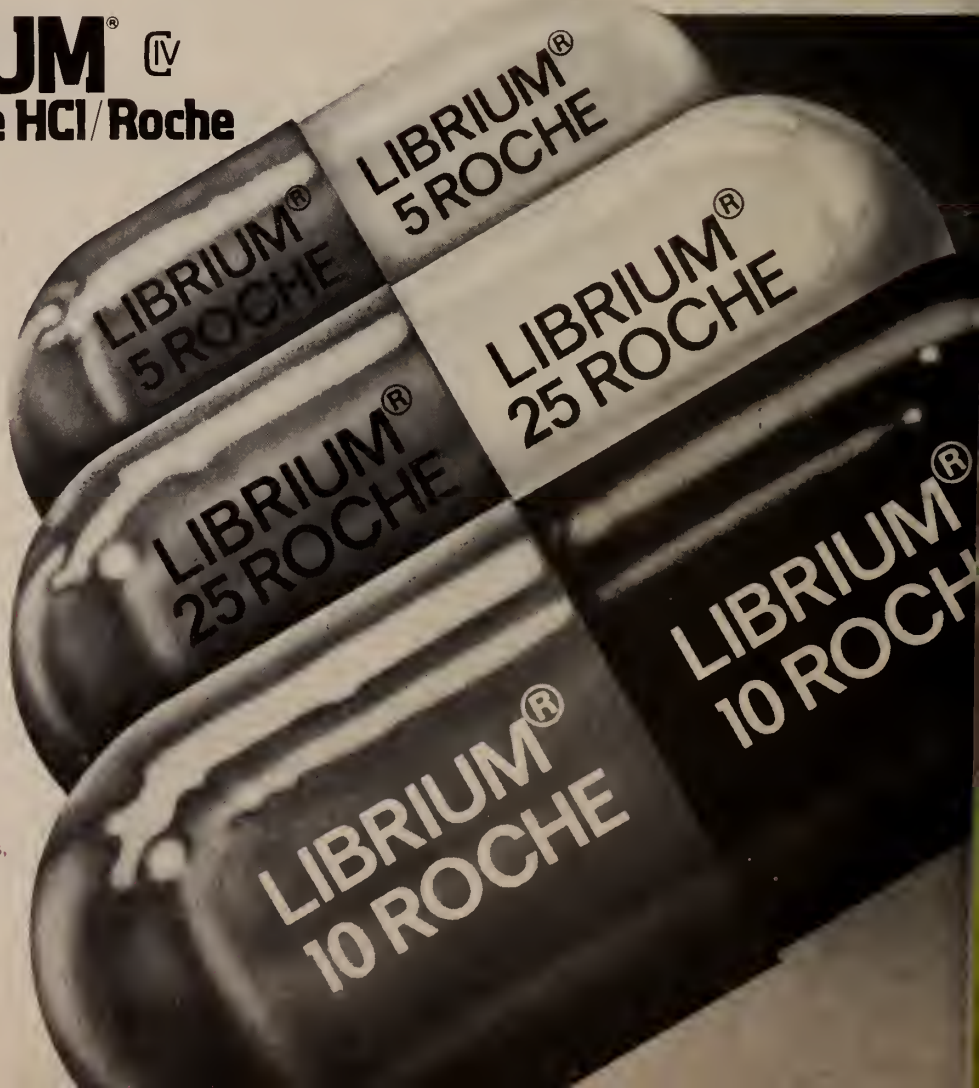
The published record on Librium is enormous. So large, in fact, we put it into a computer literature retrieval system to make it more accessible in answering your inquiries.*

It's a record that reveals a consistent pattern of patient response. A highly favorable benefits-to-risk ratio. And minimal interference with many primary medications.

Doing one thing well. Basically, that's what Librium is all about.

**LIBRIUM®** Ⓘⓥ
**chlordiazepoxide HCl/Roche**

LIBRARY
FEB 24 1978
NEW YORK ACADEMY OF MEDICINE




ROCHE

*If you have a question about Librium or any other Roche product, write to Professional Services, Roche Laboratories, Nutley, New Jersey 07110.

Please see preceding page for a summary of product information.

BALCOM

# Illinois Medical Journal

OFFICIAL JOURNAL OF THE
ILLINOIS STATE MEDICAL SOCIETY

Volume 153, No. 3, March, 1978

NEW YORK ACADEMY OF
LIBRARY, PERIODI
T 103RD ST
ORK, NEW

## ISMS Annual Meeting

## April 2-5, 1978

## Palmer House, Chicago

of Contents . . . 171
lents Page . . . 247

Program . . . 201



# EMPIRIN® COMPOUND
# c CODEINE

Each tablet contains: aspirin 227 mg, phenacetin 162 mg, and caffeine 32 mg, plus codeine phosphate in one of the following strengths: #4—60 mg (gr 1); #3—30 mg (gr ½); #2—15 mg (gr ¼); and #1—7.5 mg (gr ⅛). [Warning—may be habit forming.]

C III

Burroughs Wellcome Co.
Research Triangle Park
North Carolina 27709

IMJ

Illinois Medical Journal

MARCH, 1978 Vol. 153, No. 3 CONTENTS

179 Abstracts of Board of Trustees Actions

*Clinical Articles*

193 Frequent Questions About Long-Acting, Injectable Fluphenazine
*By Mark A. Amdur, M.D./Chicago*

*Convention Program*

203 Members of the 1978 House of Delegates
204 Downstate Delegates
205 Cook County Delegates
206 Officers of County Medical Societies
211 Agenda of the House of Delegates
213 Committees of the House of Delegates
214 Program Summary by Days
215 Auxiliary Convention Program
216 Resolutions
218 Student Business Session Annual Meeting Program

*Special Articles*

244 Illinois Department of Public Health Policy Regarding Amygdalin-Laetrile

*President's Page*

247 Tonic or Snake Oil?
*George T. Wilkins, Jr., M.D.*

*(Contents continued on overleaf)*

## *Features*


180 EKG of the Month

182 Viewbox

185 Obituaries

188 Housestaff News

197 Illinois Council on Continuing Medical Education

229 Guest Editorial

230 Pulse of the Doctor's Wife

232 Classified Advertising

236 ISMS Physician Recruitment Program

239 Clinics for Crippled Children

245 Doctor's News

251 Illinois Society, American Association of Medical Assistants


## *Staff*


**Managing editor** ..... **Richard A. Ott**

**Assistant editor** ..... **Mariann E. McGuire**

**Executive administrator** ..... **Roger N. White**


*(Cover by Richard A. Ott)*


PUBLICATIONS COMMITTEE

Lawrence L. Hirsch, M.D., Chicago, *Chairman*
Kenneth A. Hurst, M.D., Naperville
Robert P. Johnson, M.D., Springfield
Alfred J. Kiessel, M.D., Decatur


---

**Contributor in Surgery:** John M. Beal, M.D., Chicago
Contributor in Maternal Death Studies:
Robert Hartman, M.D., Jacksonville
Contributor in Pediatric Perplexities: Ruth Andrea Seeler, M.D., Chicago
Contributor in Radiology: Leon Love, M.D., Maywood
Contributor in Cardiology: John R. Tobin, M.D., Maywood
Contributor in Immunopathology: Richard J. Ablin, Ph.D., Chicago
Contributor in Rheumatology: L. F. Layfer, M.D., Cbicago


ILLINOIS STATE MEDICAL SOCIETY

OFFICERS

George T. Wilkins, M.D., President
3165 Myrtle, Granite City 62040
David S. Fox, M.D., President-Elect
826 E. 61st St., Chicago 60637
Theodore Grevas, M.D., 1st Vice-President
2701 17th St., Rock Island 61201
William M. Lees, M.D., 2nd Vice-President
6518 Nortb Nokomis, Lincolnwood 60646
Eugene P. Johnson, M.D., Secretary-Treasurer
P.O. Box 68, Casey 62420

HOUSE OF DELEGATES

Cyril C. Wiggisboff, M.D., Speaker
25 E. Washington, Suite 1805, Chicago 60602
Robert P. Johnson, M.D., Vice Speaker
108 Maple Grove, Springfield 62707

TRUSTEES

1st District: 1980, John Ring, M.D.
Mundelein
2nd District: 1980, Allan L. Goslin, M.D.
712 N. Bloomington, Streator 61364
3rd District: 1980, Herschel Browns, M.D.
4600 N. Ravenswood, Chicago 60640
3rd District: 1979, Alfred Clementi, M.D.
675 W. Central Rd., Arlington Heigbts 60005
3rd District: 1980, Audley F. Connor, Jr., M.D.
3233 King Dr., Chicago 60616
3rd District: 1978, Harold J. Lasky, M.D.
55 E. Washington, Chicago 60602
3rd District: 1979, Robert T. Fox, M.D.
2136 Robincrest, Glenview 60025
3rd District: Jere E. Freidheim
3050 S. Wallace, Chicago 60616
3rd District: 1978, Henrietta Herbolsbeimer, M.D.
5528 S. Hyde Park Blvd., Apt. 1202, Chicago 60637
3rd District: 1978, Lawrence L. Hirscb, M.D.
2434 Grace, Chicago 60618
3rd District: 1978, Eugene T. Hoban, M.D.
6429 North Ave., Oak Park 60302
3rd District: 1980, Joseph C. Sherrick, M.D.
303 E. Superior, Chicago 60611
4tb District: 1979, Fred Z. White, M.D.
723 N. 2nd St., Chillicothe 61523
5th District: 1979, Paul F. Mahon, M.D.
326 N. 7th St., Springfield 62702
6th District: 1978, Robert R. Hartman, M.D.
1515 A. W. Walnut, Jacksonville 62650
7tb District: 1979, Alfred J. Kiessel, M.D.
1 Powers Lane Pl., Decatur 62521
8th District: 1979, James Laidlaw, M.D.
104 W. Clark, Champaign 61820
9tb District: 1978, Warren D. Tuttle, M.D.
203 N. Vine St., Harrisburg 62946
10th District: 1978, Julian W. Buser, M.D.
6600 W. Main, Belleville 62223
11th District: 1980, Kenneth A. Hurst, M.D.
52 Bunting Lane, Naperville 60450
12th District: 1980, P. John Seward, M.D.
2400 N. Rockton, Rockford 61101
Trustee-At-Large: Joseph Skom, M.D.
707 Fairbanks Ct., Chicago 60611
Chairman of the Board: Robert T. Fox, M.D.
2136 Robincrest, Glenview 60025



Microfilm copies of current as well as some back issues of the *Illinois Medical Journal* may be purchased from Xerox University Microfilm, 300 North Zeeb Road, Ann Arbor, Mich. 48106.

Contents of *IMJ* are listed in the *Current Contents/Clinical Practice.*

Published by the Illinois State Medical Society, 55 E. Monroe St., Chicago, Ill. 60603 (312-782-1654)



Copyright, 1978. The Illinois State Medical Society. All material subject to this copyright may be photocopied for the noncommercial purpose of scientific or educational advancement.



Subscription $8.00 per year, in advance, postage prepaid, for the United States, Cuba, Puerto Rico, Philippine Islands and Mexico. $10.00 per year for all foreign countries included in the Universal Postal Union. Canada $8.50. U.S. Single current copies available at $1.00 ($1.10 by mail), back issues $1.50.

Second class postage paid at Chicago, Ill. When moving please notify Journal office of new address including old mailing label with notification, if possible. POSTMASTER: Send notice on form No. 3579 to Illinois State Medical Society, 55 E. Monroe St., Chicago, Ill. 60603.

Pharmaceutical advertising must be approved by the ISMS Publications Committee. Other advertising accepted after review by Publications Committee or Board of Trustees. All copy or plates must reach the Journal office by the fifteenth of the month preceding publication. Rates furnished upon request.

Original articles will be considered for publication with the understanding that they are contributed only to the *Illinois Medical Journal.* The ISMS denies responsibility for opinions and statements expressed by authors or in excerpts, other than editorial or allied views or statements which reflect the authoritative action of the ISMS or of reports on official actions, policies or positions. Views expressed by authors do not necessarily represent those of the Society: any connection with official policies is coincidental.

The *Illinois Medical Journal* is published by the Illinois State Medical Society as an educational and professional informational magazine and distributed as a benefit of membership in the Illinois State Medical Society. Its intent is to keep members current in medical knowledge and is a part of a continuing medical education program. Socioeconomic matters, affecting as they do a changing pattern in the proper delivery of medical care, are considered an inherent element in medical education.

# PERFORMANCE. PROVEN EFFECTIVENESS WITHIN A WIDE SAFETY MARGIN.




While Roche Laboratories already knows more about the performance of Librium than anyone else, we keep on learning every day.

For example, the highly favorable benefits-to-risk ratio of Librium is a well-documented matter of record.

And, of course, the specific calming action of Librium has been demonstrated in millions of patients around the world. In a large number of these patients, Librium was used concomitantly with other primary medications.

Proven performance within a wide safety margin. Basically, that's what Librium is all about.

# LIBRIUM® Ⓘⓥ

## chlordiazepoxide HCl/Roche

## THE ANXIETY-SPECIFIC

**Before prescribing, please consult complete product information, a summary of which follows:**

**Indications:** Relief of anxiety and tension occurring alone or accompanying various disease states.

**Contraindications:** Patients with known hypersensitivity to the drug.

**Warnings:** Warn patients that mental and/or physical abilities required for tasks such as driving or operating machinery may be impaired, as may be mental alertness in children, and that concomitant use with alcohol or CNS depressants may have an additive effect. Though physical and psychological dependence have rarely been reported on recommended doses, caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported.

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

**Precautions:** In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

**Adverse Reactions:** Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

**Supplied:** Librium® Capsules containing 5 mg, 10 mg or 25 mg chlordiazepoxide HCl. Libritabs® Tablets containing 5 mg, 10 mg or 25 mg chlordiazepoxide.

ROCHE

Roche Products Inc.
Manati, Puerto Rico 00701

# A New Vision of Catapres® (clonidine HCl)

# 20/20



## The first 20 days

- Catapres lowers blood pressure promptly.
- No contraindications.
- Some patients may have dry mouth, drowsiness, and sedation. Tell them that these tend to diminish with continued use.
- Giving the larger part of the divided dose at bedtime can help alleviate drowsiness and sedation.

## The next 20 years*

- Lowered blood pressure.
- Little impotence, depression or postural hypotension.
- No fatal hepatotoxicity in over a decade of worldwide use.
- Broad therapeutic dosage range to keep step with changing dosage needs over the years.

*Tolerance may develop in some patients, necessitating a reevaluation of therapy.

For full details on adverse reactions, warnings, and precautions, see brief summary of the prescribing information on last page of this advertisement.



**Catapres®** (clonidine HCl)
**For Step 2 in Hypertension**

## HYPERTENSION

# A New Vision of Catapres®
# (clonidine HCl)

Tablets of 0.1 and 0.2 mg




## What you do the first 20 days Can help him the next 20 years

**Catapres®**
**(clonidine hydrochloride)**
Tablets of 0.1 mg and 0.2 mg

**Indication:** The drug is indicated in the treatme hypertension. As an antihypertensive drug, Cata (clonidine hydrochloride) is mild to moderate in It may be employed in a general treatment progr with a diuretic and/or other antihypertensive ag as needed for proper patient response.

**Warnings:** Tolerance may develop in some patie necessitating a reevaluation of therapy.
*Usage in Pregnancy:* In view of embryotoxic finc animals, and since information on possible adv effects in pregnant women is limited to uncontr clinical data, the drug is not recommended in w who are or may become pregnant unless the po benefits outweigh the potential risk to mother a
*Usage in Children:* No clinical experience is ava with the use of Catapres (clonidine hydrochlori children.

**Precautions**: When discontinuing Catapres (clo hydrochloride), reduce the dose gradually over 2 4 days to avoid a possible rapid rise in blood pr and associated subjective symptoms such as n ness, agitation, and headache. Patients should instructed not to discontinue therapy without co their physician. Rare instances of hypertensive lopathy and death have been recorded after ces of clonidine hydrochloride therapy. A causal rel ship has not been established in these cases. I been demonstrated that an excessive rise in blo sure, should it occur, can be reversed by resum of clonidine hydrochloride therapy or by intrave nous phentolamine. Patients who engage in pot tially hazardous activities, such as operating m or driving, should be advised of the sedative ef This drug may enhance the CNS-depressive eff alcohol, barbiturates and other sedatives. Like agent lowering blood pressure, clonidine hydro should be used with caution in patients with se coronary insufficiency, recent myocardial infarc cerebrovascular disease or chronic renal failure

As an integral part of their overall long-term patients treated with Catapres (clonidine hydrc should receive periodic eye examinations. Whil except for some dryness of the eyes, no drug-r abnormal ophthalmologic findings have been r with Catapres (clonidine hydrochloride), in sev studies the drug produced a dose-dependent i in the incidence and severity of spontaneously ring retinal degeneration in albino rats treated 6 months or longer.

**Adverse Reactions:** The most common reactio dry mouth, drowsiness and sedation. Constipa dizziness, headache, and fatigue have been re Generally these effects tend to diminish with c therapy. The following reactions have been ass with the drug, some of them rarely. (In some ir an exact causal relationship has not been esta These include: Anorexia, malaise, nausea, vom parotid pain, mild transient abnormalities in li tion tests; one report of possible drug-induce titis without icterus and hyperbilirubinemia in receiving clonidine hydrochloride, chlorthalidc papaverine hydrochloride. Weight gain, transie tion of blood glucose, or serum creatine phosp congestive heart failure, Raynaud's phenomer dreams or nightmares, insomnia, other behavi changes, nervousness, restlessness, anxiety a depression. Also rash, angioneurotic edema, h urticaria, thinning of the hair, pruritus not ass with a rash, impotence, urinary retention, incr sensitivity to alcohol, dryness, itching or burn eyes, dryness of the nasal mucosa, pallor, gyn mastia, weakly positive Coombs' test, asympt electrocardiographic abnormalities manifeste Wenckebach period or ventricular trigeminy.

**Overdosage:** Profound hypotension, weakness lence, diminished or absent reflexes and vom lowed the accidental ingestion of Catapres (c hydrochloride) by several children from 19 mo 5 years of age. Gastric lavage and administrat analeptic and vasopressor led to complete rec within 24 hours. Tolazoline in intravenous dos 10 mg at 30-minute intervals usually abolishe fects of Catapres (clonidine hydrochloride) ov

**How Supplied:** Catapres, brand of clonidine h chloride, is available as 0.1 mg (tan) and 0.2 (orange) oval, single-scored tablets in bottles and 1000.

For complete details, please see full presc information.

Under license from Boehringer Ingelheim C

Boehringer Ingelheim Ltd.
Ridgefield, CT. 06877

Blue Cross® Blue Shield®

# REPORT FOR Illinois Physicians

## Workshops for Medical Assistants Start in April

Letters and reservation forms are being sent to physicians' offices in central and downstate counties of Illinois inviting medical assistants to attend the Spring '78 series of workshops sponsored by the Illinois Blue Shield Plan.

The meetings will begin on April 5 in Marion, Ill. and end June 7 in Kankakee. Except for a May 17 location to be determined, arrangements for the morning and afternoon programs have been completed. The schedule of dates and locations appears below.

Medical assistants will be invited to attend either a morning or afternoon meeting. A complimentary luncheon is included for all who participate. Registration for the morning program will begin at 9:00 A.M., and the program will be in session from 9:30 until 12:00 noon. After the luncheon, the program is repeated at 1:00 P.M. with adjournment at 3:30 P.M.

To facilitate discussions of topics, the workshops will be divided into advanced and beginner groups. Staff members of the Professional Relations Department will conduct the sessions. The agenda will include a review and discussion of information in the Blue Shield Report to Medical Assistants; changes in the Medical Assistants' Handbook; also the new Physician's Service Report form and Major Medical claim form.

For additional information on the workshops, please write or phone the Professional Relations Department, Blue Cross and Blue Shield, 233 North Michigan Ave., Chicago, Illinois 60601. Phone (312) 661-4489.

**Schedule of Workshops**

| | | |
|---|---|---|
| Wed., April 5 | Ramada Inn | Marion |
| Thurs., April 6 | Holiday Inn | Mt. Vernon |
| Wed., April 12 | Augustine's | Belleville |
| Thurs., April 13 | Holiday Inn | Edwardsville |
| Thurs., April 20 | Ramada Inn | Effingham |
| Thurs., April 27 | Ramada Inn | Champaign |
| Wed., May 3 | Ramada Inn | Quincy |
| Wed., May 3 | Henrici | Rockford |
| Thurs., May 4 | Holiday Inn | Macomb |
| Thurs., May 4 | Henrici | Rockford |
| Wed., May 10 | Holiday Inn | Decatur |
| Thurs., May 11 | Forum 30 | Springfield |
| Wed., May 17 | (To be announced) | |
| Thurs., May 18 | Ramada Inn | Ottawa |
| Wed., May 24 | Ramada Inn | Bloomington |
| Thurs., May 25 | Ramada Inn | Peoria |
| Wed., May 31 | Sheraton Inn | Rock Island |
| Thurs., June 1 | Sheraton Inn | Galesburg |
| Wed., June 7 | Holiday Inn | Kankakee |

## Coordination of Benefits Designed To Limit Overpayments

Coordination of Benefits is a group contract provision designed to limit the combined payment of health care programs to no more than the total covered charges incurred. Most Blue Cross-Blue Shield groups and employer insurance programs now incorporate this provision in their contracts.

Our Plan is in agreement with most other health benefit underwriters on certain basic rules in determining which carrier will have primary liability when two or more coverages are involved and either or both have coordination of benefits provisions:

(1) The health care plan in which the patient is insured has the primary responsibility. The spouse's group plan has secondary responsibility for health care costs not covered by the primary carrier.

(2) When a dependent child receives care, the father's group plan, provided he has a family plan, has primary responsibility.

(3) When the patient is covered under two group plans as an employee, the plan under which he has been covered for the longest time is considered primary.

Health care plans which an employee or member of the employee's family purchase as an individual (not through a group) are not affected by the COB provisions outlined above.

It is the responsibility of the insurance carriers to determine the extent of liability of the companies or Plans involved. Providing as much information as possible to each carrier about other coverage in force will shorten this process, reduce correspondence and prevent unnecessary delays in payment of benefits.

## Health Care Legislation Aimed at Fraud and Abuse

On October 25, 1977, the President signed Public Law 95-142, the "Medicare-Medicaid Anti-Fraud and Abuse Amendments." This new law is intended to strengthen the Government's capability to detect, prosecute, and punish fraudulent activities in Federal health care programs and to make other technical improvements.

The elimination of fraud and abuse in these programs in one of the Administration's highest priorities, and the enactment of this new law is expected to greatly improve the quality of health care.

## Increased Penalties for Violation Of the Assignment Agreement

An assignment is a contract *between a physician and a patient* wherein both parties agree that benefit payment is made to the physician, and the physician agrees to accept the reasonable or allowed charge as the full charge. The Carrier pays the physician 80% of the reasonable charge over and above the $60 deductible. The physician may collect only the *20% coinsurance, whatever amount went toward the $60 deductible and any noncovered services.*

Failure to abide by this agreement results in a violation of the assignment agreement. When a patient complains to his Social Security office or the Carrier, the Carrier must contact the physician and explain the commitment involved in accepting assignment. The Carrier must insist that the physician refund the patient any monies erroneously collected. If a physician continues to violate the assignment agreement, the Carrier, under direction from the Regional Office of the Social Security Administration, will refuse to make payments on assigned claims by this particular physician since the Carrier's contractual responsibility is to pay only when the physician accepts the reasonable charge as his full charge.

Physicians who agree to accept Medicare assignments and then repeatedly charge patients more than the coinsurance and deductible (if any) are guilty of misdemeanors, punishable by a maximum fine of $2000, up to six months' imprisonment or both.

## INCREASED PENALTIES FOR FRAUD

The penalties for fraudulent acts under Medicare and Medicaid are upgraded from misdemeanors to felonies, punishable by a maximum fine of $25,000, up to five years' imprisonment, or both.

## Name of Physician Important On Medicare Claim

In order to process a Medicare claim, it is essential that the first and last name of the physician who rendered the service is identified. The name of a group, or a letterhead listing all of the physicians in a group, is not sufficient information since each physician has his own Medicare provider number. When such letterhead billing forms are used, the specific physician who rendered the service should be underlined, circled, or identified in some way on the bill. Failure to provide this information will result in a delay of the claim, or payment being shown under an incorrect physician's name.

## Change in Participation, Ownership, Location of Labs

Notice was received from the Bureau of Health Insurance office, Social Security Administration of the following changes in participation, ownership and location of laboratories in the Medicare program.

**Closings:** (Three laboratories below).

Rapid Medical Services
6994 North Central Park
Chicago, Illinois 60645
Provider Number: 14-8333
Effective Date: December 10, 1977

Amerco Portable X-Ray Service
2320 North Damen Ave.
Chicago, Illinois 60647
Provider Number: 14-9812
Effective Date: December 5, 1977

Avenue Medical Laboratory
12717 Ridgeland Ave.
Palos Heights, Illinois 60463
Provider Number: 14-8063
Effective Date: January 21, 1978

**Relocation:**

Royal Medical Laboratory (Provider Number 14-8332) relocated to 3940 W. Division St., Chicago, Illinois 60651, effective December 26, 1977.

**Changed Ownership:**

Forest Hill Medical Center
9050 West 81st Street
Justice, Illinois 60458
Provider Number: 14-8323
Effective Date: November 1, 1977

# *Abstracts of Board Actions*

**February 11-12, 1978** **Chicago**

*These abstracts are published so that members of the Illinois State Medical Society may keep advised of the actions of the Board of Trustees. It covers only major actions and is not intended as a detailed report. Full minutes of the meetings are available upon any member's request to the headquarters office of the ISMS.*

## CHAMPUS Contract

ISMS will contract with the Wisconsin Physicians' Service to perform peer review, facilities review and professional relations on behalf of the CHAMPUS program in Illinois. The peer review reimbursement rate will be $38, with county societies receiving $35 per review and ISMS retaining $3 to cover administrative costs.

## CNA-Medicare Reimbursement

ISMS will challenge the validity of CNA Insurance Company data used to determine Medicare prevailing charges for various procedures in the DuPage, Kane, Will and Lake County areas. Statistics formulated by the DuPage County Medical Society on an "individual medical psychotherapy procedure" will be cited in questioning CNA's data. The DuPage statistics also will be offered to AMA to assist in developing legislation mandating that Medicare fees be based solely upon UCR.

## Budget/Dues Increase

The Board approved a 1978 ISMS budget based upon anticipated gross income of $1,990,890 . . . and net operating income (after allocations) of $1,753,444. With expenses expected to reach $1,946,548, a deficit of $193,104 is anticipated. The deficit will be incurred because this marks the sixth year dues have remained $131, thus exceeding by one year the dues maintenance plan adopted when the House of Delegates set dues at the current level.

At its April meeting, the House will be asked to approve a $70 dues increase—effective Jan. 1, 1979—which would set dues at $201. The recommendation will be accompanied by a dues maintenance plan designed to hold dues at the $201 mark through 1983. The increase would cover a 6% annual increase in expenses—enough to offset inflation . . . retire the deficit . . . build sound reserves . . . and allow for necessary program expansion.

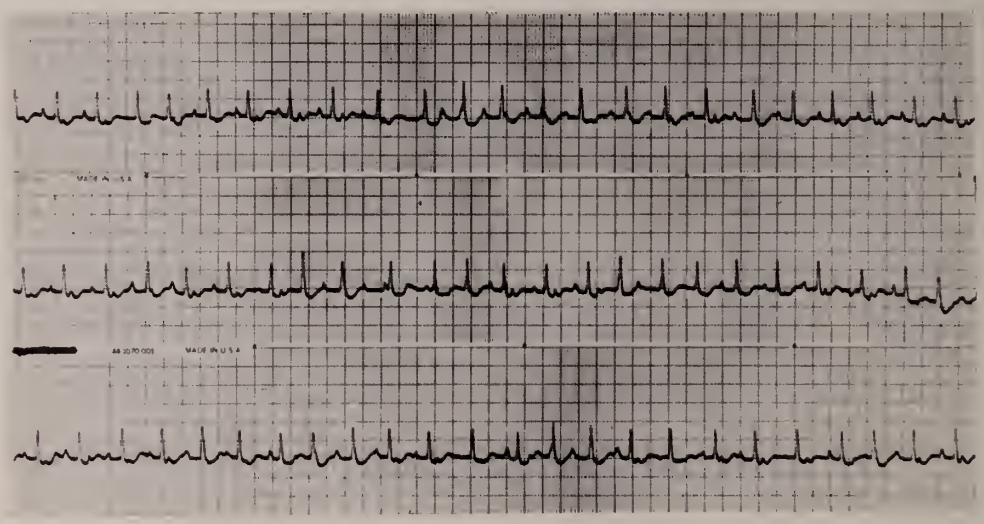
The Board also will recommend that—irrespective of any other dues increase—1979 dues be increased by an additional $5 per member to provide support for ICCME to a maximum of $15 per member, without reduction in the current $10 per member provided to AMA/ERF . . . and that fiscal '79 financial support for ICCME be provided by the ISMS Board to the limit of the foregoing allocation based upon the needs—including provisions for contingencies—as determined and recommended by the ISMS Finance Committee.

*(Continued on page 225)*

# ekg of the month

John F. Moran, M.S., M.D., David L. Fishman, M.D.,
Patrick J. Scanlon, M.D., Sarah A. Johnson, M.D.,
John R. Tobin, M.S., M.D., and Rolf M. Gunnar, M.S., M.D.
Section of Cardiology, Department of Medicine,
Loyola University Stritch School of Medicine

A seventy-two year old man was presented to the emergency service with marked shortness of breath. He had a forty-year history of cigarette smoking. He admitted to some dyspnea on exertion in the past several years, but his breathlessness had markedly worsened in the past two days. His examination demonstrated an elderly man in acute respiratory distress, utilizing his accessory muscles of respiration. He was slightly cyanotic. His blood pressure was normal and his pulse was irregular at approximately 150 beats per minute. He had poor ventilatory breath sounds, an enlarged A-P diameter of the chest, and bilateral fine moist crepitant rales. A ventricular gallop ($S_3$) was heard at the apex of the heart. The single channel ECG rhythm strip was taken.

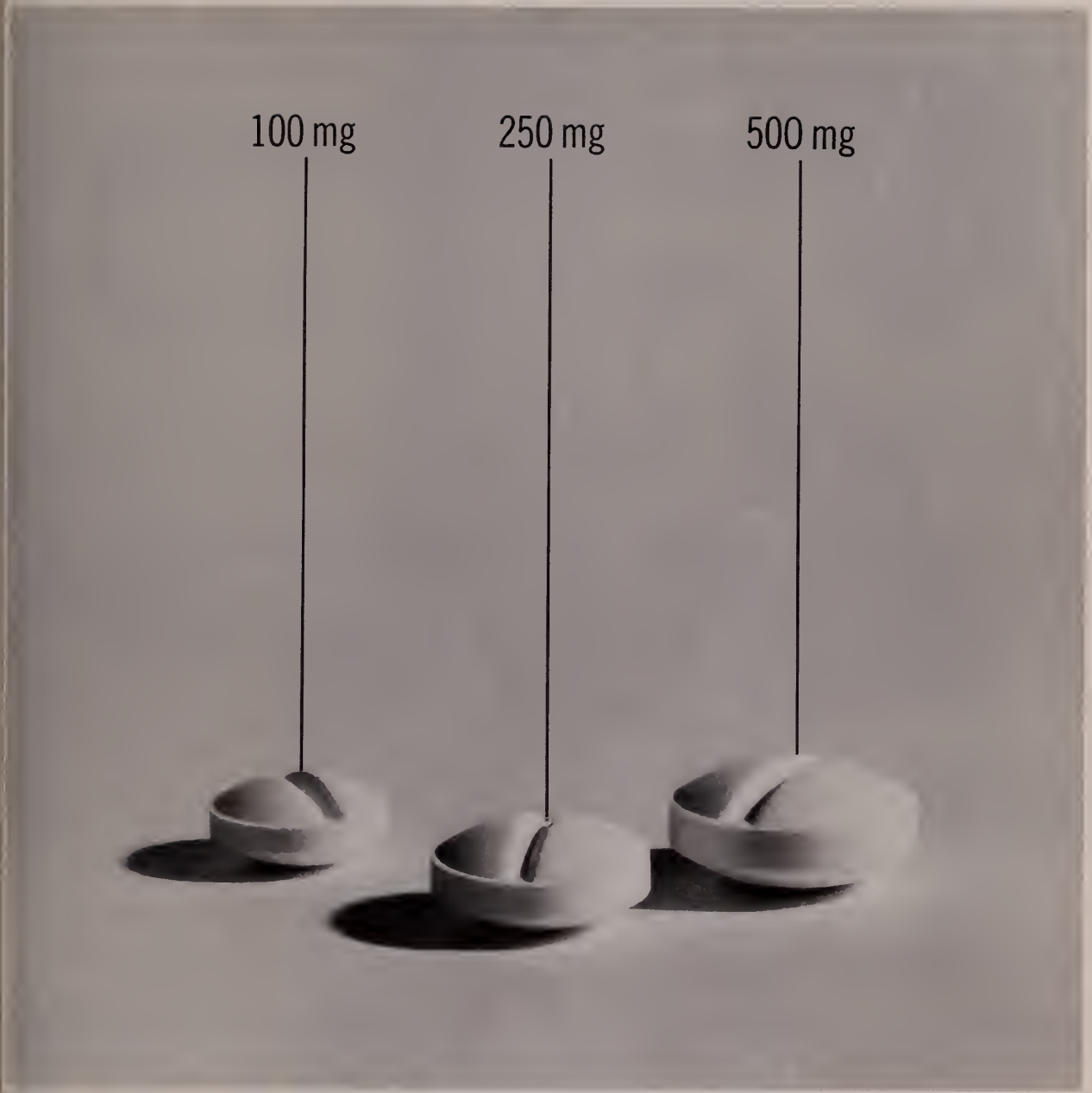


## *Questions:*

1. The ECG shows:
   A. Atrial flutter with 2:1 atrioventicular block.
   B. Atrial fibrillation with a rapid ventricular response.
   C. Junctional tachycardia.
   D. Multifocal atrial tachycardia.
   E. Ventricular tachycardia.

2. Treatment of this patient should include:
   A. Arterial blood gases.
   B. Chest X-ray.
   C. Digitalis parenterally.
   D. Pulmonary function studies.
   E. Endotracheal intubation and positive pressure respiratory assistance device.

*(Continued on page 242)*



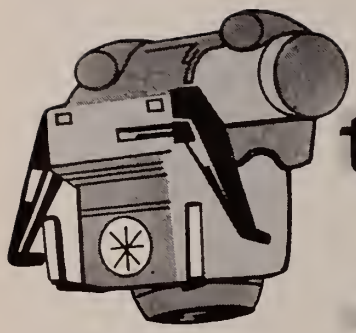

# Tolinase®
## tolazamide, Upjohn

Please contact your Upjohn representative for additional product information.

Upjohn

J-5695-6

©1977 THE UPJOHN COMPANY



# the view box

Leon Love, M.D./Chairman/Department of Radiology
Loyola University Stritch School of Medicine

This is a 21-year-old man who complained of dysuria, abdominal pain, and vomiting of about one week's duration.



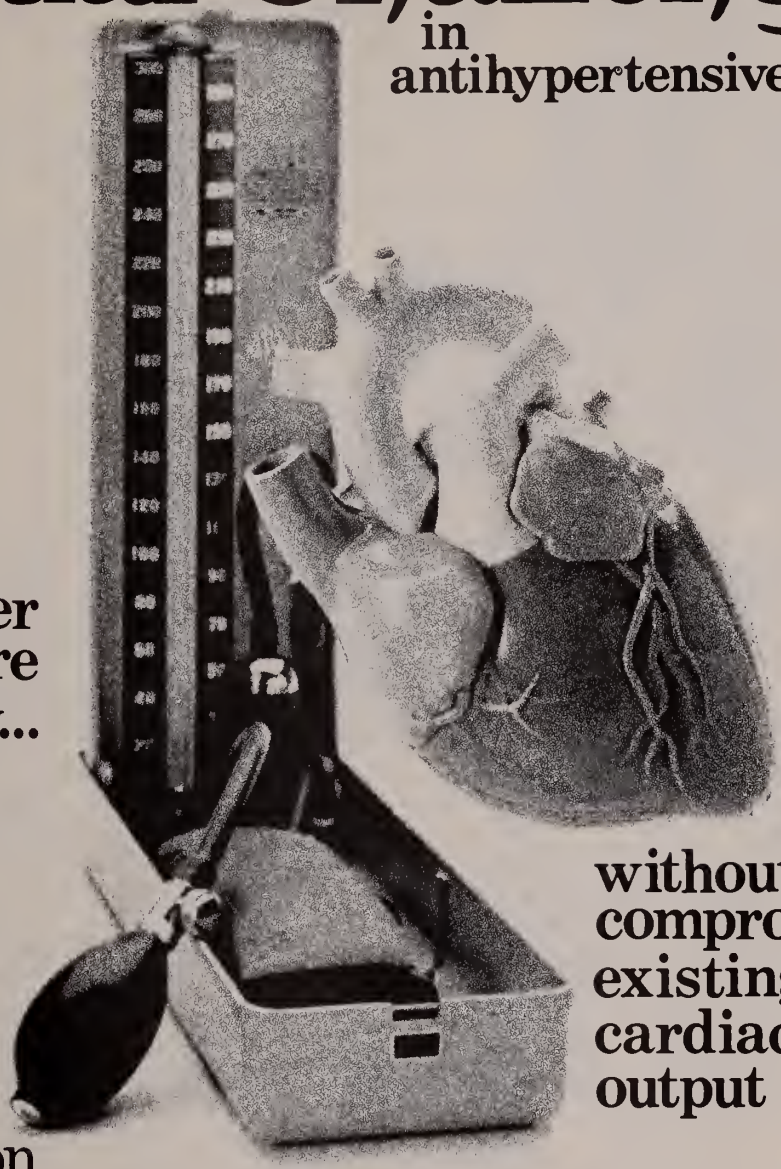
**Figure 1**

## *What's your diagnosis?*

1. Retroperitoneal fibrosis
2. Crohn's disease
3. Appendiceal abscess
4. Infected Mullerian duct cyst

*(Continued on page 250)*

# A Dual Challenge in antihypertensive therapy



to lower blood pressure effectively...

without compromising existing cardiac output

in hypertension

TABLETS: 250 mg, 500 mg, and 125 mg

# ALDOMET® (METHYLDOPA | MSD)

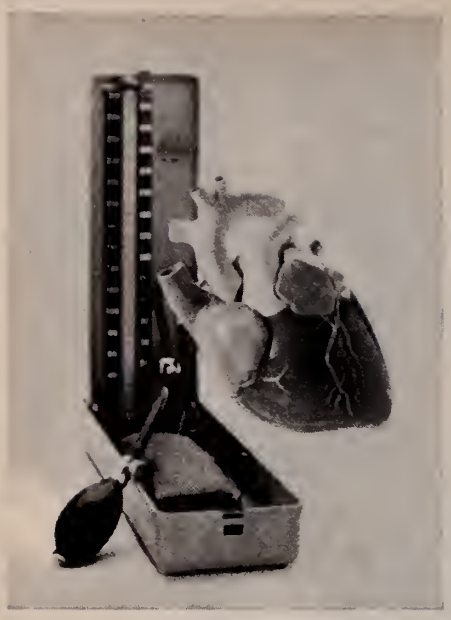
helps lower blood pressure effectively... usually with no direct effect on cardiac function–cardiac output is usually maintained

ALDOMET is contraindicated in active hepatic disease, hypersensitivity to the drug, and if previous methyldopa therapy has been associated with liver disorders.

It is important to recognize that a positive Coombs test, hemolytic anemia, and liver disorders may occur with methyldopa therapy. The rare occurrences of hemolytic anemia or liver disorders could lead to potentially fatal complications unless properly recognized and managed. For more details see the brief summary of prescribing information.

**For a brief summary of prescribing information, please see following page.**

MSD
MERCK SHARP & DOHME



in hypertension

# ALDOMET®

## (METHYLDOPA|MSD)

helps lower blood pressure effectively... usually with no direct effect on cardiac function– cardiac output is usually maintained

**Contraindications:** Active hepatic disease, such as acute hepatitis and active cirrhosis; if previous methyldopa therapy has been associated with liver disorders (see Warnings); hypersensitivity.

**Warnings: It is important to recognize that a positive Coombs test, hemolytic anemia, and liver disorders may occur with methyldopa therapy. The rare occurrences of hemolytic anemia or liver disorders could lead to potentially fatal complications unless properly recognized and managed. Read this section carefully to understand these reactions.**

With prolonged methyldopa therapy, 10% to 20% of patients develop a positive direct Coombs test, usually between 6 and 12 months of therapy. Lowest incidence is at daily dosage of 1 g or less. This on rare occasions may be associated with hemolytic anemia, which could lead to potentially fatal complications. One cannot predict which patients with a positive direct Coombs test may develop hemolytic anemia. Prior existence or development of a positive direct Coombs test is not in itself a contraindication to use of methyldopa. If a positive Coombs test develops during methyldopa therapy, determine whether hemolytic anemia exists and whether the positive Coombs test may be a problem. For example, in addition to a positive direct Coombs test there is less often a positive indirect Coombs test which may interfere with cross matching of blood.

At the start of methyldopa therapy, it is desirable to do a blood count (hematocrit, hemoglobin, or red cell count) for a baseline or to establish whether there is anemia. Periodic blood counts should be done during therapy to detect hemolytic anemia. It may be useful to do a direct Coombs test before therapy and at 6 and 12 months after the start of therapy. If Coombs-positive hemolytic anemia occurs, the cause may be methyldopa and the drug should be discontinued. Usually the anemia remits promptly. If not, corticosteroids may be given and other causes of anemia should be considered. If the hemolytic anemia is related to methyldopa, the drug should not be reinstituted. When methyldopa causes Coombs positivity alone or with hemolytic anemia, the red cell is usually coated with gamma globulin of the IgG (gamma G) class only. The positive Coombs test may not revert to normal until weeks to months after methyldopa is stopped.

Should the need for transfusion arise in a patient receiving methyldopa, both a direct and an indirect Coombs test should be performed on his blood. In the absence of hemolytic anemia, usually only the direct Coombs test will be positive. A positive direct Coombs test alone will not interfere with typing or cross matching. If the indirect Coombs test is also positive, problems may arise in the major cross match and the assistance of a hematologist or transfusion expert will be needed.

Fever has occurred within first 3 weeks of therapy, occasionally with eosinophilia or abnormalities in liver function tests, such as serum alkaline phosphatase, serum transaminases (SGOT, SGPT), bilirubin, cephalin cholesterol flocculation, prothrombin time, and bromsulphalein retention. Jaundice, with or without fever, may occur, with onset usually in the first 2 to 3 months of therapy. In some patients the findings are consistent with those of cholestasis. Rarely fatal hepatic necrosis has been reported. These hepatic changes may represent hypersensitivity reactions; periodic determination of hepatic function should be done particularly during the first 6 to 12 weeks of therapy or whenever an unexplained fever occurs. If fever and abnormalities in liver function tests or jaundice appear, stop therapy with methyldopa. If caused by methyldopa, the temperature and abnormalities in liver function characteristically have reverted to normal when the drug was discontinued. Methyldopa should not be reinstituted in such patients.

Rarely, a reversible reduction of the white blood cell count with primary effect on granulocytes has been seen. Reversible thrombocytopenia has occurred rarely. When used with other antihypertensive drugs, potentiation of antihypertensive effect may occur. Patients should be followed carefully to detect side reactions or unusual manifestations of drug idiosyncrasy.

*Pregnancy and Nursing:* Use of any drug in women who are or may become pregnant or intend to nurse requires that anticipated benefits be weighed against possible risks; possibility of fetal injury or injury to a nursing infant cannot be excluded. Methyldopa crosses the placental barrier, appears in cord blood, and appears in breast milk.

**Precautions:** Should be used with caution in patients with history of previous liver disease or dysfunction (see Warnings). May interfere with measurement of: urinary uric acid by the phosphotungstate method, serum creatinine by the alkaline picrate method, and SGOT by colorimetric methods. Since methyldopa causes fluorescence in urine samples at the same wavelengths as catecholamines, falsely high levels of urinary catecholamines may be reported. This will interfere with the diagnosis of pheochromocytoma. It is important to recognize this phenomenon before a patient with a possible pheochromocytoma is subjected to surgery. Methyldopa is not recommended for patients with pheochromocytoma. Urine exposed to air after voiding may darken because of breakdown of methyldopa or its metabolites.

Stop drug if involuntary choreoathetotic movements occur in patients with severe bilateral cerebrovascular disease. Patients may require reduced doses o anesthetics; hypotension occurring during anesthesia usually can be controlled with vasopressors. Hypertension has recurred after dialysis in patients or methyldopa because the drug is removed by this procedure.

**Adverse Reactions:** *Central nervous system:* Seda tion, headache, asthenia or weakness, usually early and transient; dizziness, lightheadedness, symptom of cerebrovascular insufficiency, paresthesias, parkinsonism, Bell's palsy, decreased mental acuity, involuntary choreoathetotic movements; psychic disturbances, including nightmares and reversible mild psychoses or depression.

*Cardiovascular:* Bradycardia, aggravation of angina pectoris. Orthostatic hypotension (decrease dail dosage). Edema (and weight gain) usually relieved b use of a diuretic. (Discontinue methyldopa if edem progresses or signs of heart failure appear.)

*Gastrointestinal:* Nausea, vomiting, distention, constipation, flatus, diarrhea, mild dryness of mouth, sor or "black" tongue, pancreatitis, sialadenitis.

*Hepatic:* Abnormal liver function tests, jaundice, live disorders.

*Hematologic:* Positive Coombs test, hemolytic anemia Leukopenia, granulocytopenia, thrombocytopeni Positive tests for antinuclear antibody, LE cells, an rheumatoid factor.

*Allergic:* Drug-related fever, lupus-like syndrom myocarditis.

*Other:* Nasal stuffiness, rise in BUN, breast enlarg ment, gynecomastia, lactation, impotence, decrease libido, dermatologic reactions including eczema ar lichenoid eruptions, mild arthralgia, myalgia.

**Note:** Initial adult dosage should be limited to 500 m daily when given with antihypertensives other tha thiazides. Tolerance may occur, usually between se ond and third months of therapy; increased dosage adding a diuretic frequently restores effective contr Patients with impaired renal function may respond smaller doses. Syncope in older patients may be r lated to increased sensitivity and advanced a teriosclerotic vascular disease; this may be avoid by lower doses.

**How Supplied:** Tablets, containing 125 m methyldopa each, in bottles of 100; Tablets, containi 250 mg methyldopa each, in single-unit packages 100 and bottles of 100 and 1000; Tablets, containi 500 mg methyldopa each, in single-unit packages 100 and bottles of 100 and 500.

*For more detailed information, consult your M representative or see full prescribing informati*

*Merck Sharp & Dohme, Division of Merck & Co., In West Point, Pa. 19486*

J6AM07R1(7

**MSD** MERCK SHARP & DOHME

## *Obituaries*

°Adelman, Robert, Sterling, died January 5 at the age of 69. Doctor Adelman was a 1935 graduate of the Chicago Medical School.

°Bottom, Donald S., Alton, died December 31 at the age of 67. Doctor Bottom was a 1940 graduate of Washington University School of Medicine.

°Cymbalisty, Ihor P., Chicago, died February 7 at the age of 53. Doctor Cymbalisty was a 1950 graduate from Innsbruck, Austria.

°°Davis, M. Edward, Chicago, died February 6 at the age of 78. Doctor Davis was a 1923 graduate of Rush Medical College.

°°Feldman, Louis, Chicago, died January 13 at the age of 82. Doctor Feldman was a 1924 graduate of the University of Illinois.

°°Freese, Arthur W., Chicago, died February 3 at the age of 93. Doctor Freese was a 1909 graduate of the University of Illinois.

°Grossman, Edward S., Lincolnwood, died January 16 at the age of 63. Doctor Grossman was a 1940 graduate of the University of Illinois.

°°Joseph, Paul, Chicago, died February 9, at the age of 73. Doctor Joseph was a 1928 graduate from Bonn, Germany.

°Kolatalo, Walter W., Rockford, died February 1 at the age of 56. Doctor Kolatalo was a 1948 graduate of the University of Marburg, Germany.

°Lerner, Aaron, Chicago, died February 5 at the age of 73. Doctor Lerner was a 1930 graduate of the University of Illinois.

°Lifschultz, Leo B., Chicago, died February 5 at the age of 76. Doctor Lifschultz was a 1929 graduate of the Chicago Medical School.

°°Nardi, John B., Palatine, died January 19 at the age of 102. Doctor Nardi was a 1911 graduate of Northwestern University.

°°Owen, Alfred Beam, Rockford, died January 28 at the age of 82. Doctor Owen was a 1924 graduate of Northwestern University.

°Saletta, Charles A., Chicago, died December 17 at the age of 68. Doctor Saletta was a 1935 graduate of the Chicago Medical School.

°°Schmitt, Milton George, Hot Springs, California (formerly of Des Plaines) died January 18 at the age of 75. Doctor Schmitt was a 1928 graduate of Northwestern University.

*°Indicates ISMS member*
*°°Indicates ISMS member of the Fifty Year Club*



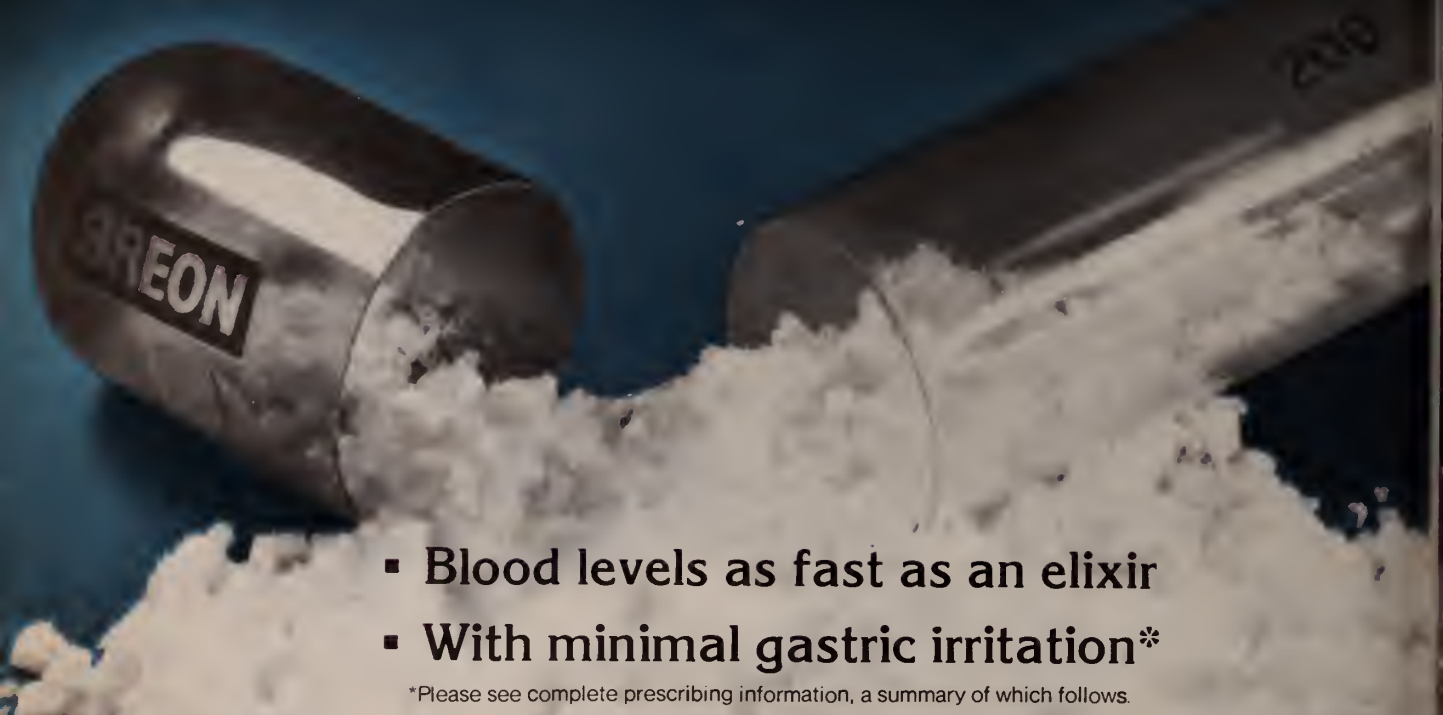
Modane®
(danthron)
LAXATIVE TABLETS
one tablet usually brings gentle, overnight relief
WARREN-TEED
LABORATORIES, INC.
DIVISION OF AORIA LABORATORIES INC.
COLUMBUS, OHIO 43215

# A Difference in Theophylline Therapy

## micro-pulverized

# BRONKODYL® Capsules

brand of theophylline, USP anhydrous




- Blood levels as fast as an elixir
- With minimal gastric irritation*

*Please see complete prescribing information, a summary of which follows.

DESCRIPTION:
Each green and white hard gelatin capsule contains theophylline USP anhydrous, 200 mg., in a micro-pulverized form. Each brown and white hard gelatin capsule contains 100 mg. The elixir contains 80 mg. theophylline per 15 ml. in a 20% alcohol elixir (approximately 20 calories, 0.9 gm carbohydrate per tablespoonful).

ACTION: Theophylline is a methylxanthine which relaxes the smooth musculature of the bronchioles through its inhibition of the conversion of cyclic adenosine monophosphate to adenosine monophosphate by phosphodiesterase. It also has diuretic, cardiotonic, and CNS stimulant effects.

INDICATIONS: Bronkodyl is indicated for symptomatic relaxation of bronchiolar spasm in the chronic obstructive bronchopulmonary diseases; e.g., bronchial asthma, chronic bronchitis and pulmonary emphysema.

CONTRAINDICATIONS: Bronkodyl is contraindicated in persons known to have had serious idiosyncratic responses to theophylline, its salts, or the other methylxanthines, theobromine, or caffeine and may be contraindicated in peptic ulcer.

WARNINGS: All methylxanthines should be used with caution in children and in others who are currently taking bronchodilator products, especially in rectal dosage form, which may contain theophylline or related drugs.

USAGE IN PREGNANCY: Although theophylline has been used for many years, with no evidence of adverse fetal effect or teratogenicity, its safety in pregnancy has not been established. Therefore use of Bronkodyl during lactation or in women of childbearing potential requires that possible benefits of the drug be weighed against possible hazards to fetus or child.

PRECAUTIONS: Bronkodyl should be used with caution in patients with cardiac or circulatory disease.

ADVERSE REACTIONS: Gastrointestinal: Epigastric distress, nausea, vom ing. Cardiovascular: palpitations. CNS: Insomnia, restlessness, irritability, co vulsion.

DOSAGE AND ADMINISTRATION: Adults: Usual dosage of Bronkodyl is 2( mg. every 6 hours (four doses in each 24 hours). This dosage may be adjuste to reflect individual clinical response as an indication of slow or rapid meta olism of the drug. If adverse reactions are encountered, each dose may t reduced, or the interval between doses may be lengthened, or both. If clinic response is not satisfactory, indicating possible rapid inactivation of the dru dosage may be gradually increased to achieve the desired response. In son instances of either too slow or too rapid metabolism, plasma levels of the phylline should be determined and dosage adjusted accordingly to achie levels above 10 mcg/ml, but not to exceed 20 mcg/ml.

Dosage in Children: Usual dosage should be based on administration of 10 n per kg per 24 hours, divided in 4 doses per day, given every 6 hours. As this m not be possible with use of the capsules, Bronkodyl elixir may be used. The phylline saliva levels (approximately 60% of simultaneous blood levels), m facilitate dosage adjustments, especially in children, to obtain appropria response.

HOW SUPPLIED:
Bronkodyl 100 mg., brown and white capsules in 100's, Code #1831.
Bronkodyl 200 mg., green and white capsules in 100's, Code #1833.
Bronkodyl Elixir, 80 mg. per 15 ml, in pints, Code #1835.

BREON LABORATORIES INC.
90 Park Avenue, New York, N.Y. 10016

"Texas physicians report on a self-administered peritoneal dialysis system...Dr. Salk protests widespread news reports of imminent cure for multiple sclerosis...a survey of malpractice cases uncovers the most common causes of claims...Canadian cardiologists offer a technique for diagnosing angina caused by coronary-artery spasm...the IRS is clamping down on tax shelters but some programs still work...CT scanning is shown to detect hidden abdominal injuries resulting from auto accidents.."

**Important things are happening that you should know about right away. You'll find them on your desk every two weeks in Medical World News, the newsmagazine of medicine.**

**Read this one first.**

**medical world news**

A McGraw-Hill publication






# US-FMG's: A Vanishing Breed

By Linda L. Hughey, M.D./Wilmette

*This is a monthly column which welcomes contributions, comments, and questions from interested readers. Address all correspondence to Dr. Linda Hughey, c/o the Illinois Medical Journal, 55 E. Monroe, Chicago, Ill. 60603.*

The Foreign Medical Gradaute (FMG) is a vanishing breed. As the number of U.S. residency positions has been shrinking to become an accurate reflection of the number of U.S. medical school graduates, the obvious casualties are the FMGs who formerly filled many of the extra positions. Most FMGs ostensibly came for "training" only in the U.S., but in practice many of them arrived with no intention of returning to their native lands and thousands of FMGs joined the ranks of American physicians.

Why did they come? The reasons are not subtle or mysterious. They came for the same reasons settlers have arrived in the U.S. for the last three and a half centuries. They came to earn a living, to enjoy a higher standard of living and to ploy their trade. In America physicians enjoy an economic status and prestige far above that of physicians in most other countries. Further, in the U.S., FMGs can practice the type of medicine they were taught in school. Many foreign schools have curricula oriented towards urban acute-care medicine despite the fact that the people really need more rural-based, basic-hygiene and public health-oriented medical care. Naturally, physicians trained in a sophisticated urban model gravitate to a place where that type of practice is available, i.e., the U.S.

FMGs were welcomed into training programs in the U.S. They filled the spots U.S. M.G.s did not want; they put up with long hours, poor working conditions and poor educational programs for the opportunity to stay in America. And stay they did; many of them outsmarted the system designed to send them home and overcame educational handicaps to become top-notch American physicians. Unfortunately, some did not overcome educational handicaps and squeezed by to become poorly trained American physicians. And in the long run, the FMGs did little to alleviate the distribution problems of U.S. medicine. Like U.S. M.G.s, the FMGs concentrated in the cities and the specialties where the U.S. already had an abundance of physicians.

At last the trend has slowed. The outcries of rejected U.S. applicants pointed to the absurdity of admitting FMGs into a system already turning away qualified American applicants. The number of American medical students increased at the same time the number of residency positions was cut back—effectively cutting down on the number of FMGs who could obtain American residencies.

The trend has slowed, but many questions remain to be answered. What is to be the fate of FMGs currently in training? What are the criteria by which FMGs in the future may be admitted for training? For practice? Most likely, FMG's will come in small numbers and be able to qualify for licensure under the same standards FMGs already in practice in the U.S. They should, of course, be expected to demonstrate continued competency, just as USMGs should. If our requirements for licensure are valid, we should not have to worry about where someone received training but only that the training is adequate to practice contemporary American medicine.




**I'm just a shadow of what I used to be."**

That is what depressed individuals may feel is the substance of their being. There is no pleasure, no joy—nothing grows—and in the cold shadow of depression their activities are inhibited, while initiative may be eroded or destroyed. The tragedy is that they can see that others are able to live on the brighter side but they, themselves, cannot reach it on their own.

Your experience in treating depression, and Tofranil-**PM** can help light the way.

Tofranil-**PM**®
imipramine **pamoate**

Geigy

Unsurpassed effectiveness among tricyclics in relieving symptoms of anxious depression.

Before prescribing Tofranil-PM, please review a summary of the prescribing information on the back of this page.

# Tofranil-PM®
## imipramine pamoate

# Geigy

As anxiety, agitation, sleep disturbances, and other depressive symptoms are relieved, mood and motivation may be markedly improved.

Patients are usually alert and capable of functioning at more normal levels of behavior.

Tofranil-PM encourages patient compliance because one capsule lasts from bedtime to bedtime.

Good results are usually seen at the starting dose of one 75-mg capsule h.s.

For many patients, dosage can be safely increased to 150 mg daily.

As with all tricyclics, sedation may occur. Please caution patients against driving or operating dangerous machinery.

Each capsule contains imipramine pamoate equivalent to 75, 100, 125 or 150 mg of imipramine hydrochloride.

**Tofranil-PM®**
**brand of imipramine pamoate**

**Indications:** For the relief of symptoms of depression. Endogenous depression is more likely to be alleviated than other depressive states.

**Contraindications:** The concomitant use of monoamine oxidase inhibiting compounds is contraindicated. Hyperpyretic crises or severe convulsive seizures may occur in patients receiving such combinations. The potentiation of adverse effects can be serious, or even fatal. When it is desired to substitute Tofranil-PM, brand of imipramine pamoate, in patients receiving a monoamine oxidase inhibitor, as long an interval should elapse as the clinical situation will allow, with a minimum of 14 days. Initial dosage should be low and increases should be gradual and cautiously prescribed. The drug is contraindicated during the acute recovery period after a myocardial infarction. Patients with a known hypersensitivity to this compound should not be given the drug. The possibility of cross-sensitivity to other dibenzazepine compounds should be kept in mind.

**Warnings:** *Usage in Pregnancy:* Safe use of imipramine during pregnancy and lactation has not been established; therefore, in administering the drug to pregnant patients, nursing mothers, or women of childbearing potential, the potential benefits must be weighed against the possible hazards. Animal reproduction studies have yielded inconclusive results. There have been clinical reports of congenital malformation associated with the use of this drug, but a causal relationship has not been confirmed.

Extreme caution should be used when this drug is given to:

—patients with cardiovascular disease because of the possibility of conduction defects, arrhythmias, myocardial infarction, strokes and tachycardia;
—patients with increased intraocular pressure, history of urinary retention, or history of narrow-angle glaucoma because of the drug's anticholinergic properties;
—hyperthyroid patients or those on thyroid medication because of the possibility of cardiovascular toxicity;
—patients with a history of seizure disorder because this drug has been shown to lower the seizure threshold;
—patients receiving guanethidine or similar agents since imipramine may block the pharmacologic effects of these drugs.

Since imipramine may impair the mental and/or physical abilities required for the performance of potentially hazardous tasks such as operating an automobile or machinery, the patient should be cautioned accordingly.

*Usage in Children:* Tofranil-PM, brand of imipramine pamoate, should not be used in children of any age because of the increased potential for acute overdosage due to the high unit potency (75 mg., 100 mg., 125 mg. and 150 mg.). Each capsule contains imipramine pamoate equivalent to 75 mg., 100 mg., 125 mg. or 150 mg. imipramine hydrochloride.

**Precautions:** It should be kept in mind that the possibility of suicide in seriously depressed patients is inherent in the illness and may persist until significant remission occurs. Such patients should be carefully supervised during the early phase of treatment with Tofranil-PM, brand of imipramine pamoate, and may require hospitalization. Prescriptions should be written for the smallest amount feasible.

Hypomanic or manic episodes may occur, particularly in patients with cyclic disorders. Such reactions may necessitate discontinuation of the drug. If needed, Tofranil-PM, brand of imipramine pamoate, may be resumed in lower dosage when these episodes are relieved. Administration of a tranquilizer may be useful in controlling such episodes.

Prior to elective surgery, imipramine should be discontinued for as long as the clinical situation will allow.

An activation of the psychosis may occasionally be observed in schizophrenic patients and may require reduction of dosage and the addition of a phenothiazine.

In occasional susceptible patients or in those receiving anticholinergic drugs (including antiparkinsonism agents) in addition, the atropine-like effects may become more pronounced (e.g., paralytic ileus). Close supervision and careful adjustment of dosage is required when this drug is administered concomitantly with anticholinergic or sympathomimetic drugs.

Avoid the use of preparations, such as decongestants and local anesthetics, which contain any sympathomimetic amine (e.g., adrenalin, noradrenalin), since it has been reported that tricyclic antidepressants can potentiate the effects of catecholamines.

Patients should be warned that the concomitant use of alcoholic beverages may be associated with exaggerated effects.

Both elevation and lowering of blood sugar levels have been reported.

Concurrent administration of imipramine with electroshock therapy may increase the hazards; such treatment should be limited to those patients for whom it is essential, since there is limited clinical experience.

**Adverse Reactions:** Note: Although the listing which follows includes a few adverse reactions which have not been reported with this specific drug, the pharmacological similarities among the tricyclic antidepressant drugs require that each of the reactions be considered when imipramine is administered.

*Cardiovascular:* Hypotension, hypertension, tachycardia, palpitation, myocardial infarction, arrhythmias, heart block, stroke, falls.

*Psychiatric:* Confusional states (especially in the elderly) with hallucinations, disorientation, delusions; anxiety, restlessness, agitation; insomnia and nightmares; hypomania; exacerbation of psychosis.

*Neurological:* Numbness, tingling, paresthesias of extremities, incoordination, ataxia, tremors; peripheral neuropathy; extrapyramidal symptoms; seizures, alterations in EEG patterns; tinnitus.

*Anticholinergic:* Dry mouth, and, rarely, associated sublingual adenitis; blurred vision, disturbances of accommodation, mydriasis; constipation, paralytic ileus; urinary retention, delayed micturition, dilation of the urinary tract.

*Allergic:* Skin rash, petechiae, urticaria, itching, photosensitization (avoid excessive exposure to sunlight); edema (general or of face and tongue); drug fever; cross-sensitivity with desipramine.

*Hematologic:* Bone marrow depression including agranulocytosis; eosinophilia; purpura; thrombocytopenia. Leukocyte and differential counts should be performed in any patient who develops fever and sore throat during therapy; the drug should be discontinued if there is evidence of pathological neutrophil depression.

*Gastrointestinal:* Nausea and vomiting, anorexia, epigastric distress, diarrhea; peculiar taste, stomatitis, abdominal cramps, black tongue.

*Endocrine:* Gynecomastia in the male; breast enlargement and galactorrhea in the female; increased or decreased libido, impotence; testicular swelling; elevation or depression of blood sugar levels.

*Other:* Jaundice (simulating obstructive); altered liver function; weight gain or loss; perspiration; flushing; urinary frequency; drowsiness, dizziness, weakness and fatigue; headache; parotid swelling; alopecia.

*Withdrawal Symptoms:* Though not indicative of addiction, abrupt cessation of treatment after prolonged therapy may produce nausea, headache and malaise.

**Dosage and Administration:** In adult outpatients, therapy should be initiated on a once-a-day basis with 75 mg./day. This may be increased to 150 mg./day which is the dose level which usually obtains optimum response. If necessary, dosage may be increased to 200 mg./day. Dosage should be modified as necessary by clinical response and any evidence of intolerance. Daily dosage may be given at bedtime, or in some patients in divided daily doses.

Hospitalized patients should be started on a once-a-day basis with 100-150 mg./day and may be increased to 200 mg./day. Dosage should be increased to 250-300 mg./day if there is no response after two weeks.

Following remission, maintenance medication may be required for a longer period of time at the lowest dose that will maintain remission. The usual adult maintenance dosage is 75-150 mg./day on a once-a-day basis, preferably at bedtime.

In adolescent and geriatric patients, capsules of Tofranil-PM, brand of imipramine pamoate, may be used when total daily dosage is established at 75 mg. or higher. It is generally unnecessary to exceed 100 mg./day in these patients. This dosage may be given once a day at bedtime or, if needed, in divided daily doses.

**How Supplied:** Tofranil-PM, brand of imipramine pamoate. Capsules of 75, 100, 125 and 150 mg. (Each capsule contains imipramine pamoate equivalent to 75, 100, 125 or 150 mg. of imipramine hydrochloride.)
(B) 98-146-840-A(9/75) 667120

**For complete details, including dosage and administration, please refer to the full prescribing information**

GEIGY Pharmaceuticals
Division of CIBA-GEIGY Corporation
Ardsley, New York 10502

Printed in U.S.A. (10-77) TO 12889

# Over 8½%

## yield on your money... from a Government-Guaranteed Security. And the income is paid monthly.

For safety and high income...*paid monthly*... it's difficult to match GNMA Mortgage-Backed Certificates. They bear a U.S. Government guarantee on "the timely payment of both principal and interest." Since many GNMA's are now selling at discount from the original issue price, the face amount interest (varying upwards from 6%) actually yields over 8½% for current investors.*

### What Are GNMA Certificates?

GNMA stands for Government National Mortgage Association, a part of the U.S. Department of Housing and Urban Development. The money raised by the sale of these GNMA Guaranteed Certificates is used to finance mortgages. GNMA guarantees timely payment of both principal and interest on these Mortgage-Backed Certificates, and its guarantee is backed by the full faith and credit of the government of the United States of America.

When you buy a Certificate, sold by Kidder, Peabody in units of $25,000, you purchase a share of a pool of insured FHA or VA mortgages. Each certificate issued against the specific "pool" is GNMA guaranteed. You enjoy a number of advantages which were designed initially to attract money from pension funds and other institutional investors into residential and health-care facility mortgages. But if you're a substantial individual investor, you also can obtain all the benefits for your own personal "pension fund."

### Advantages of GNMA Certificates

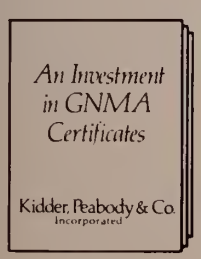
- *They currently yield over 8½% compared to an approximate 8% on comparable maturing U.S. Government Bonds.*
- *Principal and interest, and their timely payment, are guaranteed by the U.S. Government.*
- *Interest and principal comes in convenient monthly payments...ideal for wealthy retired people or those interested in current income with a high degree of safety.*
- *There are none of the traditional and often necessary burdens of ordinary mortgage investment...no legal expenses, no administrative work, and no worry about late payments.*
- *GNMA Certificates can be turned into cash more readily than ordinary mortgages.*
- *Attractive investment for large and small corporations with excess cash.*

### Write for "An Investment in GNMA Certificates"

Kidder, Peabody, one of the world's largest investment banking firms, is a major purchaser and distributor of GNMA Certificates. We also make a secondary market in Certificates which we have distributed. We've prepared a summary booklet describing this attractive income investment in detail. Write for your copy today.

**Effective 2/20/78. The yield may be higher or lower at time of publication of this message.*

IMJ-38




**Kidder, Peabody & Co.** INCORPORATED
*Founded 1865*
*Members New York and American Stock Exchanges*

**125 S. Wacker Drive, Chicago, IL 60606**
**Tel: (312) 641-7500**

New York, Boston, Philadelphia, San Francisco, Los Angeles, Atlanta, Dallas and 43 additional offices worldwide.

Gentlemen: Please send me your booklet "An Investment in GNMA Certificates"

Name_____

Address_____

City_____

State_____ Zip_____

Tel:_____

# The 1978 Annual Illinois Congress on Continuing Medical Education May 5-6, 1978

## *Accreditation, Course Approval and CME plus Selective Subjects*

CME Sponsors and Planners now face *dual* approval requirements—and face them under the newly enforced Illinois mandatory CME law.

This year's Congress is your opportunity to gain understanding of the controversy regarding Institutional Accreditation (as represented by the new LCCME) *vs.* Specialty Society Course Approval.

You'll also be able to increase skill in any of five "selective subjects" geared to the variety of degrees of sophistication and interests/concerns among our Congress group. These topics will be discussed in small groups on Friday evening.

*New and Unique Instructional Strategies for CME*

*Multi-Institutional Cooperative Planning of CME*

*Nuts and Bolts of Institutionwide Program Organization*

*CME Program Evaluation—Myth or Reality*

*ICCME Re-accreditation Preparation*

Remember, last year's Congress proved that *your* input, properly channeled, DOES make a difference.

*1978 Annual Congress on CME*
*Oak Brook Hyatt House, Oak Brook, IL*
*Friday, May 5, 7:30 PM—Saturday, May 6, 4:45 PM*

*For more information, write or call:*

Illinois Council on Continuing Medical Education
55 E. Monroe St., Suite 3510, Chicago, IL 60603
Telephone (312) 236-6110

IMJ
Illinois Medical Journal
Vol. 153, No. 3, March, 1978

# Frequent Questions About Long-Acting, Injectable Fluphenazine

By Mark A. Amdur, M.D./Chicago

*Long-acting, injectable fluphenazine (Prolixin, Squibb) is a phenothiazine of the piperazine group. This drug is indicated for the treatment and prophylaxis of certain psychotic disorders. Long-acting, injectable fluphenazine has been available for over a decade, first as the enanthate and more recently as the decanoate. Fluphenazine decanoate is increasingly popular in the outpatient management of major mental illness.*

Since 1974, pharmacotherapy with fluphenazine decanoate has been a major component of Northwestern Memorial Hospital's Institute of Psychiatry Sustaining Care Program. The Sustaining Care Program is an outpatient facility serving discharged psychiatric patients living in a specific area of Chicago's north side. Between March, 1974, and December, 1976, 185 persons received nearly 4000 injections of fluphenazine decanoate at the Sustaining Care Program. Physicians in and out of psychiatry frequently ask questions regarding fluphenazine decanoate management. The following represents an overview of some of the major clinical issues that have been raised.

MARK A. AMDUR, M.D., is the assistant director of Northwestern Memorial Hospital's Institute of Psychiatry Sustaining Care Program. An assistant professor of psychiatry at Northwestern University, Doctor Amdur is board certified by the American Board of Psychiatry and Neurology.

1. *For which patients might one recommend long-acting fluphenazine?*

Depot fluphenazine is regarded as the drug of choice for outpatient management of chronic schizophrenia and chronic paranoid psychoses. It is a frequent component in the treatment of affective disorders. We do not reserve depot fluphenazine for a few "difficult" patients.

The nature of the illness being treated (lack of insight, ambivalence, poor reality contact) and the nature of the medications (unpleasant side effects, not immediately beneficial) predict poor compliance.[1] Medication maintenance is recognized as a major factor in reducing rehospitalization rates.[2] If chronically ill psychiatric patients are to be seriously managed in community settings, reliable medication administration is of particular concern.

Depot fluphenazine is eminently reliable. The physician knows precisely when and how much drug was delivered. The psychological and social parameters effecting compliance are vastly reduced. A patient taking oral fluphenazine three times a day must perform forty-five willful acts in a two-week period. A patient on depot fluphenazine must make one office visit during that same period. If that visit is missed, a home visit can be made.

There are a few instances where depot fluphenazine, while permissible, requires particular caution. Some persons who describe an "allergy" to fluphenazine may be cautiously given depot fluphenazine. Such "allergies" may represent poorly managed extrapyramidal reactions or sedation from over-aggressive treatment with depot or oral fluphenazine. The experience at the Sustaining Care Program is that young adults (under twenty-five), elderly, and brain damaged individuals are particularly sensitive to the extra-pyramidal effects of depot fluphenazine. In such cases depot fluphenazine may be used, but the dosage is increased more slowly.

2. *In which specific circumstances might one avoid depot fluphenazine?*

Persons who have not had multiple, recent psychotic decompensations and who are without troubling symptoms should be left unmedicated or on oral medications. Stable persons living in the community do not become more stable through medication change. Some patients have responded with disruption to a change in old medication habits. Other patients accept the injection but will not discontinue old oral medications.

Management with depot fluphenazine should not be initiated for individuals who may be moving away and consulting a new physician. Few patients fully comprehend the notion of an injectable medication that has a latent onset and protracted period of action. They may either forget the name of their medication or forget to mention that they received the injections when giving a medical history. The result can be a confused clinical picture when a patient, not under regular supervision, presents at a new facility needing either "a shot" or relief from an extrapyramidal reaction.

A certain number of newly diagnosed "schizophrenics" appear, on longitudinal observation, to have actually had hysterical or toxin-induced psychoses. Depot fluphenazine holds no special benefits for these persons. Confidence in diagnosis and chronicity should be obtained prior to initiating depot fluphenazine. Although the risk for phenothizines in early pregnancy is not established,[3] depot fluphenazine is not given to pregnant women and those likely to become pregnant in the near future. Because the drug can have an active duration of up to six weeks and is irrevocable, depot fluphenazine is not administered to persons with a labile medical status or to persons who may be candidates for major surgery in the near future. Persons actively abusing alcohol or other sedative drugs are not given depot fluphenazine.

## Dosage and Side Effects

3. *What might be the usual dosage of depot fluphenazine?*

Depot fluphenazine has been used to manage acute psychotic episodes in previously unmedicated inpatients and outpatients. In such cases dosages may be high and injections are daily or on alternate days. Chien and Cole[4] have published a protocol for acute management.

The central concept for utilizing depot fluphenazine successfully in *non-emergent* situations is individualized treatment. At the Sustaining Care Program, treatment is initiated with an injection of $\frac{1}{8}$ cc (25 milligrams/cc). A second injection of $\frac{1}{8}$ or $\frac{1}{4}$ cc is given five to seven days later. Patients are seen at least weekly. If symptoms indicate and side effects are manageable, dosage is increased by $\frac{1}{4}$ cc per week. After six to eight weeks, if the clinical picture is stable, the patient may be switched to a bimonthly schedule receiving the same dosage or $1\frac{1}{2}$ times the weekly dosage.

For two to three weeks after the first injection patients are asked to continue on an oral major tranquilizer. If the clinical situation is pressing, depot fluphenazine is given without prior administration of oral fluphenazine. If a leisurely approach is possible, 2.5 or 5 milligrams of oral fluphenazine at bedtime is prescribed for five to seven days before administering the first injection.

Most patients are asked to come for shots every one or two weeks. Generally, only those patients who are working come less frequently. Scheduling relatively frequent visits encourages habit formation. Frequent appointments facilitate close monitoring for management of side effects and changes in mental status. Monitoring and management is most efficient and competent

when performed by the same physician or nurse-practitioner on each visit.

Maintenance dosages at the Sustaining Care Program have varied from 1/8 cc every three weeks to 2½ cc every week. The largest dosage that we have administered on a single visit was 3¼cc. We do not give single injections greater than 2 cc. A survey of the most recent injection of all individuals (83) receiving fluphenazine decanoate between July and December of 1976 showed dosages as follows: 1/8cc (7.2%), ¼ cc (29.0%), ½cc (20.5%), ¾ cc (8.4%), 1 cc (21.6%), greater than 1 cc (13.3%).

Patient's needs are not necessarily constant. A conscientious program should be sensitive to this fact and provide more than mechanistic administration of fixed dosages. During September and October of 1975, 40% of those persons regularly receiving depot fluphenazine required a physician-initiated dose change because of altered mental status or side effects.

There is no accurate method for predicting the required dosage of depot fluphenazine. Equivalence to the oral dosage of other major tranquilizers, including oral fluphenazine, is not known. To avoid confusion, depot fluphenazine dosage is usually described by volume since the milligram dosage of depot fluphenazine is not clinically comparable to oral drugs.

Unitized 1 cc injections of depot fluphenazine are not recommended. They tend to prejudice against the use of individualized fractional dosages.

4. *What is the difference between fluphenazine enanthate and fluphenazine decanoate?*

The enanthate and the decanoate are both long-acting injectable preparations. The enanthate form was initially marketed in the mid-sixties. The decanoate was introduced approximately six years ago and is now more widely used. Preference for decanoate is related to a claimed longer period of action[5] and lower incidence of side effects.[6]

5. *What are the typical problems with side effects?*

Clinically significant side effects of depot fluphenazine are those common to major tranquilizers: dry mouth, sedation, blurry vision, amenorrhea, postural hypotension, skin sensitivity, and extrapyramidal reactions. Non-extrapyramidal side effects can usually be managed with dose reduction, reassurance, or patience.

Patients at the Sustaining Care Program do not routinely receive prophylactic anti-Parkinsonian medications. Nonetheless, a majority of persons who received four or more injections at the Sustaining Care Program required treatment for extrapyramidal symptoms at some time. Typical extrapyramidal reactions are dystonia (oculogyric crisis), akinesia (masked facies, the "zombie look") and akathesia (restless legs).

Oculogyric crisis is very frightening but rapidly managed by parenteral benztropine or diphenylhydramine. Oral anti-Parkinsonian medications should be continued after an acute episode. Akinesia can be treated with anti-Parkinsonian medication, although we generally attempt dose reduction of fluphenazine. Akathesia can be seen as jitteriness or only the subjective sense of being ill at ease. At times the symptoms are mistaken for psychotic decompensation or anxiety. A therapeutic trial of trihexyphenidyl, 5 milligrams, or benztropine, 2 milligrams, with observation for one hour will often help. Symptomatic relief normally suggests akathesia. Akathesia is an alien, frightening sensation. The experience at the Sustaining Care Program is in agreement with Van Putten[7] who found that unmanaged akathesia was a major reason for schizophrenics stopping their medications.

The Sustaining Care Program has not experienced any incidents of injection site inflammation or systemic allergic reaction. We, as others,[8] have been concerned with a possible association between depot fluphenazine and depression and suicide. From March, 1974, through December, 1975, the Sustaining Care Program had five suicides and one near-fatal attempt among the 109 persons who up until then had had four or

**Table 1**
**Guidelines for Administration of Depot Fluphenazine**

1. **Dosage may be highly individualized from person to person and from visit to visit.**
2. **Minimal doses per injection allow for accurate titration of symptoms and side effects.**
3. **Visits may be brief but ought to be frequent and with the same physician or nurse-practitioner.**
4. **The physician or nurse-practitioner must be trained to assess for subtle changes in mental status and extrapyramidal symptoms, especially depression and akathesia.**
5. **Depot fluphenazine provides only reliable medical maintenance. A broad range of additional psychological, social and vocational services constitute comprehensive psychiatric aftercare.**

more injections. Five of the six persons were young adults who were being treated with poor success for akathesia. Five of the six had a history of previous suicidal attempts and had been noted to be depressed at the time. It was partly a review of these events which prompted the development of the recommendations for small doses of depot fluphenazine at frequent intervals to allow for close clinical monitoring. Additionally we recommend special care in young adults with akathesia, depression, and a history of suicide attempts. As of December, 1977, a total of 176 persons had received four or more injections. There have been no known additional suicide attempts. The relationship between depression and fluphenazine remains unclear and is confounded by the fact that high-risk patients may have preferentially received long-acting fluphenazine.

6. *How do you convince patients to accept medication in the injectable form?*

Patients are initially told that long-acting fluphenazine is a "tranquilizer" like many others they may have had. It is unique, however, in that it is taken as a relatively painless ("except for the needlestick") injection two to four times per month. Two concerns are anticipated. First, patients are assured that the shot goes into the muscle, not into a vein. Secondly, patients are assured that the shot is given in the upper arm, not in the buttocks. The advantage of depot fluphenazine in terms of cost and convenience is stressed. There will be fewer pills to take and fewer pills to forget.

Since bioavailability of fluphenazine is presumed to be greater than oral medication, patients are told that "the shot works more efficiently." Depot fluphenazine is "the best insurance" a patient can have that he will not have a return of "the problems that led to hospitalization."

Paranoid, suspicious persons are most likely to default on oral medication. These individuals also hesitate to accept injections. "Coming on strong," coercion, or deceit usually results in loss of the patient. Some investment must be made with these persons to articulate the area in which they feel distressed. The rationale for depot fluphenazine then should be re-phrased to them in terms consistent with *their* perceived needs. For example, rather than confronting a delusional system, talk about how certain concerns might well be provoking marked anxiety or inhibiting powers of concentration. The "shot" would then be described in terms of alleviating anxiety and enhancing ability to concentrate on the affairs of daily living. Suspicious patients usually appreciate an approach designed to relieve their discomfort rather than change their ideas.

Patients living with their families often find that considerable conflict erupts over the issue of pill taking. Some patients act out their independence by not taking medications. In other cases families covertly or overtly sabotage medication compliance. The use of depot fluphenazine removes the issue of medication consumption from the families' agenda and places it solely up to the patient and the doctor. Patients are often relieved to know that the family will not be "hassling" them over pills.

Most persons who have accepted an initial injection do not decline subsequent injections. From March, 1974, through December of 1976, 23 (13% of 185) persons receiving depot fluphenazine received only one injection; one hundred forty-five (78% of 185) received four or more injections.

## Conclusion

Depot fluphenazine is unique and is increasingly used in reliable maintenance management of chronic psychotic illness. It is a long-acting, irretrievable agent that is often poorly comprehended by patients. Complete familarity with this novel medication is essential for those prescribing it. Those administering the drug should do so with a special depth of responsibility. Some specific guidelines are shown in Table 1. ◄

## References


1. Blackwell, B.: "Drug Therapy. Patient Compliance," *New England Journal of Medicine*, 289:249-252, 1973.
2. Hogarty, G. E., *et al.*: "Drug and Sociotherapy in the Aftercare of Schizophrenic Patients," *Archives of General Psychiatry*, 31:603-618, 1974.
3. Ananth, J.: "Cogenital Malformations with Psychopharmacologic Agents," *Comprehensive Psychiatry*, 16: 437-445, 1975.
4. Chien, C. P., and Cole, J. P.: "Depot Phenothiazine Treatment in Acute Psychosis," *American Journal of Psychiatry*, 130:13-18, 1973.
5. Klett, J. C., in Frank J. Ayd: *The Future of Pharmacotherapy: New Drug Delivery Systems, International Drug Therapy Newsletter*, Baltimore, p. 11, 1973.
6. Ayd, F. J., in Frank J. Ayd: *Ibid*, at p. 83, 1973.
7. Van Putten, T.: "Why do Schizophrenic Patients Refuse to Take Their Drugs," *Archives of General Psychiatry*, 31:67-72, 1974.
8. Ayd, F. J.: "The Depot Fluphenazines: A Reappraisal After 10 Year's Clinical Experience." *American Journal of Psychiatry*, 132:491-500, 1975.

# ISMS Guide to Continuing Medical Education

Compiled for Illinois physicians by the
ILLINOIS COUNCIL ON CONTINUING MEDICAL EDUCATION
55 E. Monroe St., Suite 3510 • Chicago, IL 60603 • (312) 236-6110

*Items for this Calendar must be received 90 days prior to the event. Those received earlier may appear in up to three monthly issues.*

*WARNING! Items for this Calendar come from many sources, often far in advance of the publication date. Sometimes, cancellations or changes in date, place or time occur too late to be corrected before publication. You are urged to contact the sponsoring organization to confirm information given below.*

## APRIL

### *Bioavailability*

**PRACTICAL ASPECTS OF BIOAVAILABILITY**
**For:** Physicians. 1-day confarence, April 15, 1978, Drake Hotal—Laka Shora Drive & Michigan Ava., Chicago, IL. **Hrs. of Instr.:** 7. **CME Credit:** AMA Category 1. **Fee:** $15.00. **Sponsor:** Northwastern Uniarsity Madical School, Alumni Canter for Continuing Education, 301 East Chicago Ave, Chicago, IL. **Contact:** Jamas E. Dyson, Ph.D., Diractor, Continuing Education. **Telephona:** (312) 649-8533.

### *Cardiology*

**ADVANCED EKG**
**For:** Intarnists and Family Practitionars. Lecture, April 1, 1978, Cook County Graduate School. **Speaker:** Kenneth Rosen, M.D. **Hrs. of Instr.:** 17. **CME Credit:** AMA Category 1. **Faa:** $125.00. **Sponsor:** Cook County Graduata School of Medicine, 707 Wood Street, Chicago, IL. **Contact:** Robert J. Baker, M.D., Dean. **Telephona:** (312) 733-2800.

### *Family Therapy*

**STRUCTUAL FAMILY THERAPY**
**For:** Mental Health Practitioners and Physicians. Two-day conference, April 13-14, 1978; 9:30 AM-4:30 PM. Holiday Inn-Chicago City Cantar, Chicago, IL. **Speaker:** Salvador Minuchin, M.D., Philadalphia Child Guidance Cantar. **Hrs. of Inst.:** 12. **CME Credit:** AMA Category 1. **Fee:** $70.00. **Sponsor:** Center for Family Studies/The Family Instituta of Chicago, 10 East Huron, Chicago, IL. **Co-Sponsor:** Institute of Psychiatry, Northwestarn Memorial Hospital and Northwestern Univarsity Medical School. **Contact:** Balinda Stone, Secretary. **Talaphone:** (312) 440-1414.

### *Family Therapy*

**MARITAL CONFLICT: ASSESSMENT AND INTERVENTION**
**For:** Mental Health Practitioners and Physicians. One-day workshop, April 28, 1978; 9:30 AM-4:30 PM. Center for Family Studias/The Family Institute of Chicago. **Speaker:** Larry Faldman, M.D., Staff/Faculty. **Hrs. of Inst.:** 6. **CME Credit:** AMA Catagory 1. **Faa:** $35.00. **Rag. Limit:** 50. **Sponsor:** Cantar for Family Studies/Tha Family Instituta of Chicago, 10 East Huron, Chicago, IL. **Co-Sponsor:** Institute of Psychiatry, Northwestern Memorial Hospital and Northwestern University Madical School. **Contact:** Balinda M. Stone, Secratary. **Talaphona:** (312) 440-1414.

### *General Medicine*

**CARDIAC STRESS TESTING**
**For:** Physicians. Lectura, April 4, 1978, Hanrotin Hospital Board Room, Chicago, IL. **Speakar:** Rimaudas Nemickas, M.D., Cardiologist. **Hrs. of Instr.:** . **CME Credit:** AMA Catagory 2. **Fee:** Nona. **Sponsor:** Henrotin Hospital, 111 West Oak Straet, Chicago, L. **Contact:** William N. Warnar, M.D. Associata Director of Madical Education. **Talephone:** (312) 440-755.

### *Internal Medicine*

**STATE & NATIONAL BOARD REVIEW, BASIC**
**For:** Intarnists. Lecture, April 30, 1978, Cook County Graduate School. **Speaker:** Sheldon S. Waldstain, M.D. **Hrs. of Instr.:** 58. **CME Credit:** AMA Catagory . **Fee:** $250.00. **Reg. Limit:** 150. **Sponsor:** Cook County Graduata School of Medicine, 707 South Wood Street, Chicago, IL. **Contact:** Robert J. Bakar, M.D., Dean. **Telaphona:** (312) 733-2800.

### *Oncology*

**XI ANNUAL CANCER SYMPOSIUM: CANCER OF THE COLON AND RECTUM**
**For:** Primary Care; Genaral Surgery and Intarnist. Symposium, April 14-15, 1978. **Hrs. of Inst.:** 8.5. **CME Cradit:** AMA Catagory 1, AAFP Prescribad and AOA (applied for). **Fee:** $60.00. **Rag. Deadlina:** April 7, 1978. **Sponsor:** Wayna Stata Univarsity School of Medicine, Division of Continuing Medical Education, 1206 Scott Hall, Datroit, Michigan. **Co-Sponsor:** Amarican Cancar Sociaty. **Contact:** Garald F. Priaur, Program Coordinator. **Telephona:** (313) 577-1180.

### *Pediatrics*

**SPECIALTY REVIEW IN PEDIATRICS**
**For:** Padiatricians. Lectura, April 3, 1978, Cook County Graduate School. **Speaker:** Ira DuBrow, M.D. **Hrs. of Instr.:** 42. **CME Cradit:** AMA Category 1. **Fee:** $225.00. **Reg. Limit:** 200. **Sponsor:** Cook County Graduata School of Medicine, 707 South Wood Straat, Chicago, IL. **Contact:** Robart J. Baker, M.D., Daan. **Telephone:** (312) 733-2800.

### *Psychiatry*

**BASIC REVIEW IN PSYCHIATRY**
**For:** Psychiatrists. Lecture, April 3, 1978, Cook County Graduata School of Madicine. **Speakar:** Domeena C. Renshaw, M.D. **Hrs. of Instr.:** 40. **CME Credit:** AMA Catagory 1. **Fee:** $200.00. **Reg. Limit:** 100. **Sponsor:** Cook County Graduate School of Medicina, 707 South Wood Straat, Chicago, IL. **Contact:** Robert J. Baker, M.D., Daan. **Telephone:** (312) 733-2800.

### *Psychiatry*

**PSYCHIATRY IN THE 1980's**
**For:** Psychiatrists, Physicians and all Mental Haalth Profassionals. Lectura/symposium, April 15, 1978, 8:30 AM-12:30 PM, Maywood, IL. **Hrs. of Instr.:** 4. **CME Credit:** AMA Category 1. **Fee:** $15.00. **Sponsor:** Loyola Univarsity, Stritch School of Medicine, Dapt. of Psychiatry, 2160 South First Avenue, Maywood, IL. **Contact:** Jackson A. Smith, M.D. **Telephone:** (312) 531-3272.

### *Radiology*

**DIAGNOSTIC RADIOLOGY**
**For:** Radiologists. Lecture, April 3, 1978, Cook County Graduata School. **Speaker:** Rogar D. Pinc, M.D. **Hrs. of Instr.:** 35. **CME Credit:** AMA Catagory 1. **Fea:** $200.00. **Reg. Limit:** 45. **Sponsor:** Cook County Graduate School of Madicine, 707 South Wood Straat, Chicago, IL. **Contact:** Robart J. Baker, M.D., Daan. **Telephone:** (312) 733-2800.

### *Surgery*

**CONTINUING CONTROVERSIES IN THE CARE OF THE INJURED**
**For:** Surgaons. Lectura sarias, April 12, 1978. North Chicago VA Hospital, Bldg. 50, Room 204. **Spaaker:** Robart J. Fraaark, M.D., Profassor and Chairman, Dapt. of Surgery, Loyola University. **CME Credit:** None. **Fee:** Nona. **Sponsor:** Loyola Univarsity Stritch School of Medicina, Maywood, IL. **Contact:** Karen Jonasson, Dapt. of Surgery. **Telephone:** (312) 473-9200.

### *Utilization Review*

**THE IMPACT OF CONSUMERISM ON QUALITY HEALTH CARE**
**For:** U.R. Physicians/Coordinators. Seminar/Workshops, April 28-30, 1978. **Hrs. of Inst.:** 9. **CME Credit:** AMA Catagory 1. **Fee:** $95-$130.00. **Sponsor:** American College of Utilization Reviaw Physicians, 1108 North Sacond St., Harrisburg, PA. **Contact:** Batty J. Hamman, Exacutiva Secretary. **Telephone:** (717) 697-4428.

## MAY

### *Anesthesia*

**SPECIALTY REVIEW IN ANESTHESIOLOGY**
**For:** Anasthasiologists. Lacture, May 14, 1978, Cook County Graduata School of Medicine. **Speakar:** Alon P. Winnie, M.D. **Hrs. of Instr.:** 45. **CME Credit:** AMA Catagory 1. **Fee:** $250.00. **Rag. Limit:** 300. **Sponsor:** Cook County Graduata School of Madicine, 707 South Wood Straat, Chicago, IL. **Contact:** Robert J. Bakar, M.D., Daan. **Telephone:** (312) 733-2800.

### *Cardiology*

**AUSCULTATION**
**For:** FP's IM's and Thoracic. Lectura, May 17, 1978; 2:30 PM, Cantral DuPage Hospital, Winfield Road, Winfiald, IL. **Speaker:** Robart J. Adolph, M.D., Director, Cardiac Research Laboratory, U. of Cincinnati. **Hrs. of Inst.:** 3. **CME Cradit:** AMA Category 1 and AAFP Elactiva. **Fee:** Nona. **Reg. Deadline:** May 8, 1978. **Sponsor:** DuPage County Medical Society, 26 Wast St. Charles Road, Lombard, IL. **Contact:** Lillian S. Widmar, Exacutive Secretary. **Telaphone:** (312) 495-4050.

### *Continuing Medical Education*

**1978 ANNUAL CONGRESS ON CME**
**For:** All MD's, DME's, Program Chairman. May 5-6, 1978; Oak Brook Hyatt House, Oak Brook, IL. **Hrs. of Inst.:** 9. **CME Credit:** AMA Category 2. **Fae:** $50.00. **Rag. Limit:** 100. **Rag. Daadline:** April 21, 1978. **Sponsor:** Illinois Council on Continuing Madical Education, 55 East Monroe, Suita 3510, Chicago, IL. **Contact:** Mrs. Joan Kipnis. **Talaphona:** (312) 236-6110.

### *Contemporary Medical And Surgical Management*

**PARATHYROID DISORDERS**
**For:** Physicians, Residents and Fallows. 2½-day Symposium, May 12, 13, 1978, Saint Joseph Hospital, 2900 North Laka Shore Drive, Chicago, IL. **Speaker:** Franklin D. Schwartz, M.D. and Louis T. Tanta, M.D. **Hrs. of Instr.:** 18. **CME Credit:** AMA Catagory 1. **Reg. Deadline:** April 14, 1978. **Rag. Limit:** 250. **Fee:** $50.00-$250.00. **Sponsor:** Medical Education Saint Josaph Hospital, 2900 North Lake Shora Driva, Chicago, IL. **Contact:** Sharon Afable, Admin. Asst., Madical Education. **Telaphone:** (312) 975-3454.

### *Dermatology*

**BASIC DERMATOLOGY**
**For:** Darmatologists. Lacture, May 1, 1978, Cook County Graduate School of Madicine, 707 South Wood Street, Chicago, IL. **Speakar:** Marshall Blankanship, M.D. **Hrs. of Instr.:** 35. **CME Credit:** AMA Catagory 1. **Rag. Limit:** 100. **Fee:** $200.00. **Sponsor:** Cook County Graduate School of Madicine. **Contact:** Robart J. Baker, M.D., Dean. **Telephone:** (312) 733-2800.

### *Dermatology*

**PRIMARY CARE DERMATOLOGY**
**For:** All physicians. Confarance, May 19-21, 1978, Chicago, IL. **Hrs. of Instr.:** 17. **CME Credit:** AMA Catagory 1. **Reg. Limit:** 250. **Fee:** $150.00. **Sponsor:** Northwastarn Univarsity Medical School, Center for Continuing Education, 301 East Chicago Ava., Chicago, IL. **Contact:** James E. Dyson, Ph.D., Director of Continuing Education. **Telephone:** (312) 649-8533.

*Family Medicine*

**20th ANNUAL POSTGRADUATE SEMINAR**
**For:** Family Physicians. Lecture and Seminars, May 6-8, 1978, Hyatt Regency Chicago, Chicago, IL. **Hrs. of Instr.:** 16-22. **CME Credit:** AMA Category 1 and AAFP Prescribed. **Fee:** $20.00. **Sponsor:** Illinois Academy of Family Physicians, 1200 Harger Road, Suite 405; Oak Brook, IL. **Contact:** H. Marchmont-Robinson, M.D., Executive Director. **Telephone:** (312) 325-8502.

*Family Therapy*

**A DAY WITH VIRGINIA SATIR**
**For:** Mental Health Practitioners and Physicians. One-day workshop, May 20, 1978; 9:30 AM-4:30 PM. Regency Hyatt Hotel, 150 East Wacker Drive, Chicago, IL. **Speaker:** Virginia Satir, Palo Alto, California. **Hrs. of Inst.:** 6. **CME Credit:** AMA Category 1. **Fee:** $70.00. **Sponsor:** Center for Family Studies/The Family Institute of Chicago, 10 E. Huron, Chicago, IL. **Co-Sponsor:** Institute of Psychiatry, Northwestern Memorial Hospital and Northwestern University Medical School. **Contact:** Belinda M. Stone, Secretary for Workshops/Conferences. **Telephone:** (312) 440-1414.

*Family Therapy*

**A RATIONAL APPROACH TO PAIN**
**For:** Physicians. Lecture, May 9, 1978, Sherman Hospital, Elgin, IL. **Speaker:** Alon P. Winnie, M.D., Head, Dept. of Anesthesiology, University of Illinois. **Hrs. of Inst.:** 2. **CME Category** 1. **Fee:** None. **Sponsor:** CME Committee, Sherman Hospital, 934 Center Street, Elgin, Illinois 60120. **Contact:** Mary Anne Stiegemeier, Secretary. **Telephone:** (312) 742-9800, Ext. 649.

*Internal Medicine*

**MIDWESTERN STUDY CONFERENCE**
**For:** Internists and General Practitioners. Lecture, May 11-13, 1978, Chicago, IL. **Speaker:** Ward E. Perrin, D.O. **Hrs. of Instr.:** 18. **CME Credit:** AOA (pending). **Fee:** $125.00. **Sponsor:** Chicago College of Osteopathic Medicine, 5206 South University, Chicago, IL. **Co-Sponsor:** American College of Osteopathic Internists. **Contact:** Marie E. Kowalsky, Director of Special Events. **Telephone:** (312) 947-4606.

*Internal Medicine*

**SPECIALTY REVIEW COURSE IN INFECTIOUS DISEASE**
**For:** Infectious Disease Specialists. Lecture, May 15, 1978, Cook County Graduate School of Medicine, 707 South Wood Street, Chicago, IL. **Speaker:** Stuart Levin, M.D. **Hrs. of Instr.:** 40. **CME Credit:** AMA Category 1. **Reg. Limit:** 150. **Fee:** $200.00. **Sponsor:** Cook County Graduate School of Medicine. **Contact:** Robert J. Baker, M.D., Dean. **Telephone:** (312) 733-2800.

*Internal Medicine*

**SPECIALTY REVIEW COURSE IN NEPHROLOGY**
For: Nephrologists. Lecture, May 8, 1978, Cook County Graduate School of Medicine, 707 South Wood Street, Chicago, IL. **Speaker:** Norman Simon, M.D. **Hrs. of Instr.:** 40. **CME Credit:** AMA Category 1. **Reg. Limit:** 150. **Fee:** $200.00. **Sponsor:** Cook County Graduate School of Medicine. **Contact:** Robert J. Baker, M.D., Dean. **Telephone:** (312) 733-2800.

*Internal Medicine*

**SPECIALTY REVIEW COURSE IN RHEUMATOLOGY**
**For:** Rheumatologists. Lecture, May 8, 1978, Cook County Graduate School of Medicine, 707 South Wood Street, Chicago, IL. **Speaker:** Herbert M. Rubinstein, M.D. **Hrs. of Instr.:** 40. **CME Credit:** AMA Category 1. **Reg. Limit:** 150. **Fee:** $200.00. **Sponsor:** Cook County Graduate School of Medicine. **Contact:** Robert J. Baker, M.D., Dean. **Telephone:** (312) 733-2800.

*Internal Pulmonary Medicine*

**SPECIALTY REVIEW COURSE IN PULMONARY DISEASE**
**For:** Pulmonary Specialists. Lecture, May 1, 1978, Cook County Graduate School of Medicine, 707 South Wood Street, Chicago, IL. **Speaker:** John T. Sharp, M.D. **Hrs. of Instr:** 40. **CME Credit:** AMA Category 1. **Reg. Limit:** 150. **Fee:** $200.00. **Sponsor:** Cook County Graduate School of Medicine. **Contact:** Robert J. Baker, M.D., Dean. **Telephone:** (312) 733-2800.

*Medicine*

**STATE AND NATIONAL BOARD REVIEW, CLINICAL**
**For:** Internists and Family Practitioners. Lecture, May 8, 1978, Cook County Graduate School of Medicine, 707 South Wood Street, Chicago, IL. **Speaker:** Sheldon S. Waldstein, M.D. **Hrs. of Instr.:** 53. **CME Credit:** AMA Category 1. **Reg. Limit:** 150. **Fee:** $250.00. **Sponsor:** Cook County Graduate School of Medicine. **Contact:** Robert J. Baker, M.D., Dean. **Telephone:** (312) 733-2800.

*Medicine*

**IMMUNOLOGY IN HEMATOLOGY AND ONCOLOGY**
**For:** Practicing Physicians. Lecture, May 24, 1978; 8:00 AM. Chicago, IL. **Speaker:** John Robinson, M.D. **Hrs. of Inst.:** 2. **CME Credit:** AMA Category 1. **Fee:** None. **Sponsor:** Medical Staff of Louis A. Weiss Memorial Hospital (Levinson CME Fund), 4646 North Marine Drive, Chicago, IL 60640. **Contact:** Barry J. Millman, Associate Director. **Telephone:** (312) 878-8700, Ext. 304.

*Medicine*

**CLINICAL CONSIDERATIONS IN HEMOLYTIC ANEMIAS**
**For:** Practicing Physicians. Lecture, May 10, 1978; 8:00 AM. **Speaker:** Walter Fried, M.D. **Hrs. of Inst.:** 2. **CME Credit:** AMA Category 1. **Fee:** None. **Sponsor:** Medical Staff of Louis A. Weiss Memorial Hospital (Levinson CME Fund), 4646 North Marine Drive, Chicago, IL. **Contact:** Barry J. Millman, Associate Director. **Telephone:** (312) 878-8700, Ext. 304.

*Medicine*

**FAMILY PRACTICE REVIEW**
**For:** Family Practitioners. Lecture, May 15, 1978. **Speaker** H. Marchmont-Robinson, M.D. **Hrs. of Instr.:** 45. **CME Credit:** AMA Category 1. **Reg. Limit:** 125. **Fee:** $200.00. **Sponsor:** Cook County Graduate School of Medicine. **Contact:** Robert J. Baker, M.D., Dean. **Telephone:** (312) 733-2800.

*Musculo-Skeletal Trauma*

**CLINICAL HOSPITAL PROGRAM ON MUSCULO-SKELETAL TRAUMA**
**For:** All Physicians. Lecture, May 11, 1978, 8:00-10:00 PM. John B. Murphy Auditorium, 50 East Erie Street, Chicago, IL. **Hrs. of Instr.:** 2. **CME Credit:** AAFP Elective and AMA Category 1. **Fee:** None. **Sponsor:** Chicago Committee on Trauma of the American College of Surgeons, 11255 West 74th Street, LaGrange, IL. **Co-Sponsor:** University of Chicago Hospital & Clinics. **Contact:** Mrs. Lillian Husa, Executive Secretary. **Telephone:** (312) 482-8686.

*Neurosurgery*

**SECOND ANNUAL POSTGRADUATE COURSE IN PEDIATRIC NEUROSURGERY**
**For:** Neurosurgeons. Conference, May 2-6, 1978, Chicago, IL. **Hrs. of Instr.:** 35. **CME Credit:** AMA Category 1. **Reg. Limit:** 250. **Fee:** $315.00. **Sponsor:** Northwestern University Medical School, Center for Continuing Education, 301 East Chicago Ave., Chicago, IL. **Contact:** James E. Dyson, Ph.D., Director of Continuing Education. **Telephone:** (312) 649-8533.

*Obstetrics/Gynecology*

**SPECIALTY REVIEW IN OBSTETRICS AND GYNECOLOGY**
**For:** Gynecologists and Obstetricians. Lecture, May 15, 1978, 8:00 AM, Cook County Graduate School of Medicine, Chicago, IL. **Speaker:** John G. Masterson, M.D. **Hrs. of Instr.:** 83. **CME Credit:** AMA Category 1. **Reg. Limit:** 125. **Fee:** $400.00. **Sponsor:** Cook County Graduate School of Medicine, 707 South Wood Street, Chicago, IL. **Contact:** Robert J. Baker, M.D., Dean. **Telephone:** (312) 733-2800.

*Radiology*

**REFRESHER COURSE IN DIAGNOSTIC RADIOLOGICAL PHYSICS**
**For:** Radiologists. Lecture, May 15, 1978, 8:00 AM, Cook County Graduate School of Medicine. **Speaker:** Theodore Fields, M.S. **Hrs. of Instr.:** 44. **CME Credit:** AMA Category 1. **Reg. Limit:** 75. **Fee:** $250.00. **Sponsor:** Cook County Graduate School of Medicine, 707 South Wood Street, Chicago, IL. **Contact:** Robert J. Baker, M.D., Dean. **Telephone:** (312) 733-2800.

*Surgery*

**ADVANCES IN SURGERY**
**For:** Surgeons. Lecture, May 8, 1978, 8:00 AM, Cook County Graduate of Medicine, Chicago, IL. **Speaker:** Robert J. Baker, M.D. **Hrs. of Instr.:** 40. **CME Credit:** AMA Category 1. **Reg. Limit:** 100. **Fee:** $200.00. **Sponsor:** Cook County Graduate School of Medicine, 707 South Wood Street, Chicago, IL. **Contact:** Robert J. Baker, M.D., Dean. **Telephone:** (312) 733-2800.

*Urology*

**CLINICAL PROBLEMS IN UROLOGY**
**For:** Physicians. Lecture, May 10, 1978, 2:00-5:00 PM, 950 East 59th Street, Chicago, IL: **Hrs. of Instr.:** 3. **CME Credit:** AAFP Elective and AMA Category 1. **Fee:** $20.00. **Sponsor:** The University of Chicago, Frontiers of Medicine, 950 East 59th Street, Chicago, IL. **Contact** Elaine Ehrman, Secretary. Telephone: (312) 947-5777.

# *JUNE*

*Family Medicine*

**CEREBRAL VASCULAR INSUFFICIENCY**
**For:** Physicians. Lecture, June 20, 1978; 7:30 PM. Assembly Hall, Sherman Hospital, 934 Center Street, Elgin, Illinois. **Speaker:** Hushang Javid, M.D., Professor of Surgery, Rush Medical College. **Hrs. of Inst.:** 2. **CME Credit:** AMA Category 1. **Fee:** None. **Sponsor:** CME Committee, Sherman Hospital, 934 Center St., Elgin, IL. **Contact:** Mary Anne Stiegemeier, Secretary, CME Committee. **Telephone:** (312) 742-9800.

*Family Medicine*

**NORTHERN MICHIGAN SUMMER CONFERENCE**
**For:** Family Physicians, Internists and Pediatricians. 5-day workshop course, June 25-30, 1978. Shanty Creek Lodge, Bellaire, Michigan. **Hrs. of Inst.:** 21½. **CME Credit:** AAFP Elective, AMA Category 1 and AOA Elective. **Fee:** $200.00. **Sponsor:** Office of Continuing Education, Dept. of Postgrad Med & Health Prof. Educ. Floyd C. Pennington, Ph.D., Director. Office on Continuing Education, Towsley Center, U-M, Ann Arbor, MI. **Contact:** Connie Miller, Secretary. **Telephone:** (313) 763-1423.

*Hematology*

**BLOOD BANKING**
**For:** Blood Bank Technicians. June 1-2, 1978; 8:00 AM-5:00 PM. Towsley Center, Ann Arbor, Michigan **Hrs. of Inst.:** 13. **CME Credit:** AAFP Elective, AMA Category 1 and AOA Elective. **Fee:** $75.00. **Sponsor:** Office of Continuing Education, Dept. of Postgrad. Med. & Health Prof. Educ., Office of Continuing Education, Towsley Center, U-M, Ann Arbor, MI. **Contact:** Connie Miller, Secretary. **Telephone:** (313) 763-1423.

*Medicine*

**RECENT ADVANCES IN INFECTIOUS DISEASES**
**For:** Physicians. Lecture, June 14, 1978. 950 East 59th St., Chicago, IL. **Hrs. of Inst.:** 6. **CME Credit:** AAFP Elective and AMA Category 1. **Fee:** $30.00. **Sponsor:** The University of Chicago, Frontiers of Medicine, 950 East 59th St., Chicago, IL. **Contact:** Elaine Ehrman, Secretary. **Telephone:** (312) 947-5777.

*Medicine/Surgery*

**TWENTIETH MEDICAL SURGICAL SEMINAR FOR LAKE COUNTY**
**For:** Physicians, et al. Seminar, June 21, 1978. Mother Leonarda Hall, St. Therese Hospital, Waukegan, IL. **Hrs. of Inst.:** 5. **CME Credit:** AAFP Elective, AMA Category 1 and AOA. **Fee:** None. **Reg. Deadline:** June 20, 1978. **Sponsor:** St. Therese Hospital, 2615 Washington, Waukegan, IL. **Contact:** R. M. Adelman, D.D.S., M.D., Vice President—Medical Affairs. **Telephone:** (312) 688-5800.

*Pediatric Neurosurgery*

**SECOND ANNUAL POST-GRADUATE COURSE IN PEDIATRIC NEUROSURGERY**
**For:** Pediatric Neurosurgeons. 5-day conference, June 27-July 1, 1978. Alumni Center for Continuing Education, 301 East Chicago Ave., Chicago, IL **Hrs. of Inst.:** 35. **CME Credit:** AMA Category 1. **Fee:** $315.00. **Sponsor:** Northwestern University Medical School, Alumni Center for Continuing Education. **Contact:** James E. Dyson, Ph.D., Director, Continuing Education. **Telephone:** (312) 649-8533.

*Pulmonary Medicine*

**EVALUATION OF THE PULMONARY PATIENT: AN ADVANCED SEMINAR**
**For:** Physical Therapists, Nurses, Respiratory Therapists. 3-day workshop course, June 7-9, 1978. Towsley Center, Ann Arbor, MI. **Hrs. of Inst.:** 24¾. **CME Credit:** AAFP Elective, AMA Category 1 and AOA Elective. **Fee:** None. **Sponsor:** Office of Continuing Education, Dept. of Postgrad. Med. & Health Prof. Educ., Towsley Center, U-M, Ann Arbor, MI. **Contact:** Connie Miller, Secretary. **Telephone:** (313) 763-1423.

*Surgery*

**MANAGEMENT OF COMMON SURGICAL PROBLEMS**
**For:** Surgeons. Conference, June 15-16, 1978. Chicago, IL. **Hrs. of Inst.:** 12. **CME Credit:** AMA Category 1. **Fee:** $125.00. **Reg. Limit:** 250. **Sponsor:** Northwestern University Medical School, Center for Continuing Education, 301 East Chicago Ave., Chicago, IL. **Contact:** James E. Dyson, Ph.D., Director of Continuing Education. **Telephone:** (312) 649-8533.

# This asthmatic isn't worried about his next breath...



## he's active he's effectively maintained on

# QUIBRON®

Each capsule or tablespoon (15 ml) elixir contains theophylline (anhydrous) 150 mg and glyceryl guaiacolate (guaifenesin) 90 mg. Elixir: alcohol 15%

- high theophylline for effective around-the-clock therapy
- 100% free theophylline
- individualized theophylline dosage schedule

**Indications:** For the symptomatic treatment of bronchospastic conditions such as bronchial asthma, asthmatic bronchitis, chronic bronchitis, and pulmonary emphysema.

**Dosage:** Initial: Adults: 1-2 capsules or 1-2 tablespoonfuls elixir every 6-8 hours, children 8-12: 1 tablespoonful or one capsule every 6-8 hours and children under 8: 3 to 5 mg theophylline/kg body weight every 6-8 hours. Theophylline dosage may be cautiously increased to 2000 mg/24 hr in adults or 7 mg/kg in children; monitoring of serum theophylline levels at higher dosages is recommended.

**Precautions:** Do not administer more frequently than every 6 hours, or within 12 hours after rectal dose of any preparation containing theophylline or aminophylline. Do not give other xanthine derivatives concurrently. Use in case of pregnancy only when clearly needed.

**Adverse Reactions:** Theophylline may exert some stimulating effect on the central nervous system. Its administration may cause local irritation of the gastric mucosa, with possible gastric discomfort, nausea and vomiting. The frequency of adverse reactions is related to the serum theophylline level and are not usually a problem at serum theophylline levels below 20$\mu$g/ml.

**How Supplied:** Capsules in bottles of 100 and 1000 and unit-dose packs of 100; Elixir in bottles of 1 pint and 1 gallon.

Mead Johnson

PHARMACEUTICAL DIVISION

© 1978 Mead Johnson & Company • Evansville, Indiana 47721 U.S.A. MJL 6-4220R




# Does it influence your choice of a peripheral/cerebral vasodilator*?

- Vasodilan—compatible with coexisting diseases
- Vasodilan—compatible with concomitant therapy
- Vasodilan—compatible with your total regimen for vascular insufficiency

*Indications: Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows:

Possibly Effective:

1. For the relief of symptoms associated with cerebral vascular insufficiency
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.

Final classification of the less-than-effective indications requires further investigation.

**Composition:** Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg.
Vasodilan injection, isoxsuprine HCl, 5 mg., per ml.

**Dosage and Administration:** Oral: 10 to 20 mg., three or four times daily.
Intramuscular: 5 to 10 mg. (1 or 2 ml.) two or three times daily. Intramuscular administration may be used initially in severe or acute conditions.

**Contraindications and Cautions:** There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

Parenteral administration is not recommended in the presence of hypotension or tachycardia.

Intravenous administration should not be given because of increased likelihood of side effects.

**Adverse Reactions:** On rare occasions oral administration of the drug has been associated in time with the occurrence of hypotension, tachycardia, nausea, vomiting, dizziness, abdominal distress, and severe rash. If rash appears the drug should be discontinued.

Although available evidence suggests a temporal association of these reactions with isoxsuprine, a causal relationship can be neither confirmed nor refuted.

Administration of single dose of 10 mg. intramuscularly may result in hypotension and tachycardia. These symptoms are more pronounced in higher doses. For these reasons single intramuscular doses exceeding 10 mg. are not recommended. Repeated administration of 5 to 10 mg. intramuscularly at suitable intervals may be employed.

**Supplied:** Tablets, 10 mg., bottles of 100, 1000, 5000 and Unit Dose; Tablets, 20 mg., bottles of 100, 500, 1000, 5000 and Unit Dose; Injection, 10 mg. per 2 ml. ampul, box of six 2 ml. ampuls.

U.S. Pat. No. 3,056,836

# VASODILAN®
## (ISOXSUPRINE HCl)
**20-mg tablets**

Mead Johnson PHARMACEUTICAL DIVISION

© 1978 MEAD JOHNSON & COMPANY • EVANSVILLE, INDIANA 47721 U.S.A. MJL7-4268

# Convention Handbook




# ANNUAL MEETING '78

**Members of the House of Delegates**

**Officers of County Medical Societies**

**Agenda of the House of Delegates**

**Committees of the House of Delegates**

**Program Summary by Days**

**ISMS Auxiliary Convention Program**

**Resolutions**

*The Illinois State Medical Society*
*cordially invites you to a gala*

*President's Night*
*Dinner-Dance*
*April 3, 1978*

*honoring*

**George T. Wilkins, Jr., M.D.**
**President**
**Illinois State Medical Society**

*and*

**Celebrating the**
**50th Anniversary of the**
**Illinois State Medical Society Auxiliary**

*featuring*

*Al Pierson & His Orchestra*

*Tickets — $20.00 per person*

# Members of the 1978
## Annual Meeting
# House of Delegates

### OFFICERS

President ..... George T. Wilkins, Jr.
President-Elect ..... David S. Fox
1st Vice President ..... Theodore Grevas
2nd Vice President ..... William M. Lees
Secretary-Treasurer ..... Eugene P. Johnson
Speaker of the House ..... Cyril C. Wiggishoff
Vice Speaker ..... Robert P. Johnson

### TRUSTEES

| | | | | | |
|---|---|---|---|---|---|
| First District | John J. Ring | 1978 | Fourth District | Fred Z. White | 1979 |
| Second District | Allan L. Goslin | 1980 | Fifth District | Paul F. Mahon | 1979 |
| Third District | Herschel Browns | 1980 | Sixth District | Robert R. Hartman | 1978 |
| | Alfred Clementi | 1979 | Seventh District | Alfred J. Kiessel | 1979 |
| | Audley F. Connor, Jr. | 1980 | Eighth District | James Laidlaw | 1979 |
| | Robert T. Fox | 1979 | Ninth District | Warren D. Tuttle | 1978 |
| | Jere E. Freidheim | 1978 | Tenth District | Julian W. Buser | 1978 |
| | Henrietta Herbolsheimer | 1978 | Eleventh District | Kenneth A. Hurst | 1980 |
| | Lawrence L. Hirsch | 1978 | Twelfth District | P. John Seward | 1980 |
| | Eugene T. Hoban | 1978 | Trustee-at-Large | Joseph H. Skom | |
| | Harold J. Lasky | 1978 | | | |
| | Joseph Sherrick | 1980 | | | |

### Past Presidents

| | | | |
|---|---|---|---|
| J. Ernest Breed | 1971 | Fredric D. Lake | 1975 |
| Edward W. Cannady | 1970 | Willis I. Lewis | 1954 |
| Everett P. Coleman | 1945-46 | Burtis E. Montgomery | 1966 |
| Newton DuPuy | 1968 | Edward A. Piszczek | 1965 |
| Harlan English | 1964 | Caesar Portes | 1967 |
| Edwin S. Hamilton | 1962 | Willard C. Scrivner | 1974 |
| H. Close Hesseltine | 1961 | Joseph H. Skom | 1977 |
| J. M. Ingalls | 1976 | Leo P. A. Sweeney | 1953 |
| C. J. Jannings, III | 1972 | Philip G. Thomsen | 1969 |
| Frank J. Jirka, Jr. | 1973 | | |

### Delegates to AMA

| | | |
|---|---|---|
| Herschel Browns | Jack L. Gibbs | John J. Ring |
| Allison Burdick, Jr. | Theodore Grevas | Joseph H. Skom |
| Howard C. Burkhead | Lawrence L. Hirsch | Fred A. Tworoger |
| Alfred J. Faber | Morgan M. Meyer | Charles K. Wells |
| David S. Fox | Joseph R. O'Donnell | |

### Past Trustees or Councilors

| | | | |
|---|---|---|---|
| Earl H. Blair | Third District | A. Edward Livingston | Fifth District |
| Joseph Bordenave | First District | Joseph R. O'Donnell | Eleventh District |
| Walter C. Bornemeier | Third District | Mather Pfeiffenberger | Sixth District |
| Herbert Dexheimer | Tenth District | Ralph N. Redmond | Second District |
| Alfred Faber | Third District | George Shropshear | Third District |
| George E. Giffin | Second District | Darrell H. Trumpe | Fifth District |
| Arthur F. Goodyear | Seventh District | Frederick E. Weiss | Third District |
| Lee N. Hamm | Fifth District | Charles K. Wells | Ninth District |
| Ross Hutchison | Eleventh District | Herman Wing | Third District |
| Ted LeBoy | Third District | Warren Young | Third District |
| | | Paul P. Youngberg | Fourth District |

# Delegates and Alternate Delegates
# Illinois State Medical Society

## DOWNSTATE DELEGATES

| *County* | *Delegates* | *Alternate* |
|---|---|---|
| ADAMS | Walter Stevenson, III | Marvin Grote |
| ALEXANDER | Charles L. Yarbrough | Gemo Y. Wong |
| BOND | M. K. Kaufman | Boyd McCracken |
| BOONE | M. Mijanovich | Earl Davis |
| BUREAU | Louis D. Tarsinos | Louis Lukancic |
| CARROLL | L. B. Hussey | C. G. Piper |
| CASS-BROWN | | |
| CHAMPAIGN (3) | Harold Kolb | Richard C. Adams |
| | Richard Helfrich | Michael Russo |
| | Frank Kresca | Harlan Failor |
| CHRISTIAN | M. T. Salaymeh | |
| CLARK | George T. Mitchell | Eugene P. Johnson |
| CLAY | | |
| CLINTON | Wilson L. DuComb | James A. Kirby |
| COLES-CUMBERLAND | Mack W. Hollowell | Joseph Mallory |
| CRAWFORD | M. W. Elliott | T. P. Sloan |
| DEKALB | John W. Ovitz, Jr. | |
| DEWITT | S. Kolandaivelu | Robert E. Myers |
| DOUGLAS | Humberto Mondul | Robert Arrol |
| DUPAGE (8) | Morgan M. Meyer | John V. Ryan |
| | James P. Campbell | Joseph P. McKay |
| | William C. Perkins | Neil S. Agruss |
| | William B. Frymark | Orren D. Baab |
| | Joseph R. O'Donnell | Robert D. Dooley |
| | Raymond A. Dieter | Vernon H. Bartley |
| | Thomas W. Stach | Ralph Ryan |
| | Ronald M. Severino | Harold G. Bicek |
| EDGAR | J. M. Ingalls | J. R. Shackelford |
| EDWARDS | Andrew Krajec | Paul Nierenberg |
| EFFINGHAM | | |
| FAYETTE | D. H. Rames | |
| FORD | Somchai Supawanich | Edson Etherton |
| FRANKLIN | James Durham | |
| FULTON | Jack Gibbs | Rod Maguire |
| GALLATIN | John E. Doyle | |
| GREENE | James C. Reid | Jose Parcon |
| HANCOCK | Charles F. Eddingfield | Muhammed Hafeez |
| HENDERSON | Silvino C. Lindo | |
| HENRY-STARK | Richard M. Terry | William D. Larson |
| IROQUOIS | R. K. Swedlund | J. E. Dailey |
| JACKSON | Paul P. Lorenz | Eli L. Borkon |
| JASPER | | |
| JEFFERSON-HAMILTON | James R. Heersma | H. Goff Thompson |
| JERSEY-CALHOUN | Bernard Baalman | Herman Wuestenfeld |
| JO DAVIESS | Lyle A. Rachuy | |
| KANE (4) | A. Beaumont Johnson | James C. Pritchard |
| | Wayne Leimbach | Peter Starrett |
| | James A. McDonald | William Sheehy |
| | George Shimkus | |
| KANKAKEE | Donald Parkhurst | Richard Stoval |
| KENDALL | Walter H. Brill | |
| KNOX | Jerry Ramunis | Richard M. Flacco |
| LAKE (5) | Arthur A. Woloshin | Gerald M. Goshgarian |
| | David S. Helberg | Richard K. Hawkins |
| | Earl V. Klaren | Homer Goldstein |
| | Eugene Pitts | Silverio Agujar |
| | Hugh Falls | James Creath |
| LASALLE | E. J. Fesco | Richard Schmidt |
| LAWRENCE | R. C. Kirkwood | Larry Herron |
| LEE | Donald Edwards | Kyu Jin Cho |
| LIVINGSTON | Karl T. Deterding | John C. Purnell |
| LOGAN | Glen E. Tomlinson | |
| MACON (2) | D. Statzer | C. O. Stanley |
| | J. Schrodt | |
| MACOUPIN | Robert G. England | J. K. Villigas |
| MADISON (2) | E. K. DuVivier | Edward Ragsdale |
| | Melvin Freedman | Robert Hamilton |
| MARION | E. F. Stephens, III | W. P. Plassman |
| MASON | Jack Means | |
| MASSAC | | |
| MCDONOUGH | Samuel M. Gines | John S. Goncher |
| MCHENRY | August M. Rossetti | William Larsen |
| MCLEAN (2) | Loren Boon | Robert Reardon |
| | Robert Baller | Wil Thielemann |
| MENARD | | |
| MERCER | Monty P. McClellan | James W. Hastings |
| MONROE | | E. F. Maglasang |
| MONTGOMERY | Lee Johnson | |
| MORGAN-SCOTT | Frank Norbury | Thomas Wilson |
| MOULTRIE | | |
| OGLE | Don E. Hinderliter | Vincent Traina |
| PEORIA (4) | Ernest F. Adams | John J. Taraska |
| | Gregory Spano | Dennis Garwacki |
| | Wilbert Newcomer | Ronald Kowalski |
| | Gene O. Hoerr | Thomas Cusack |
| PERRY | C. E. Cawvey | B. A. Kinsman |
| PIATT | Wm. E. Mundt | George G. Green |
| PIKE | Carlos B. Lara | Thomas C. Bunting |
| PULASKI | A. L. Robinson | |
| RANDOLPH | O. W. Pflasterer | J. S. Mathis |
| RICHLAND | Charles A. DeKovessey | Michael E. Murray |
| ROCK ISLAND (3) | James F. Duesman | Manuel O. Guerrero |
| | Donald D. Tomlin | Richard D. Retz |
| | Richard Arnell | Phillip T. Siegert |
| ST. CLAIR (3) | H. Frank Holman | Terrence G. Klingele |
| | Thomas P. Meirink | Michael G. Murphy |
| | Mays C. Maxwell | Charles C. Weiland |
| SALINE-POPE-HARDIN | A. Z. Goldstein | C. E. Seten |
| SANGAMON (4) | Towfig M. Arjmand | Jess Diamond |
| | Edward G. Ference | David B. Lewis |
| | Robert L. Prentice | Michael Snyder |
| | Gerald T. Riordan | Richard Suhs |
| SCHUYLER | Henry C. Zingher | Robert E. Cox |
| SHELBY | Theodore Little | Edwin J. Siroy |
| STEPHENSON | William H. Isham | F. H. Descourouez |
| TAZEWELL | Roger E. Neumann | Robert M. Wright |
| UNION | Robert Rader | Wm. Whiting |
| VERMILION | A. M. Taylor | W. F. Hensold |
| WABASH | R. L. Fuller | Wm. Walling |
| WARREN | K. E. Ambrose | J. Marshall |
| WASHINGTON | J. L. Beguelin | |
| WAYNE | C. J. Jannings, III | C. Loftin |
| WHITE | Phillip Boren | |
| WHITESIDE | John Hubbard | Clarence Mueller |
| WILL-GRUNDY (3) | Merle L. Otto | Kenneth M. Uznanski |
| | Guy A. Pandola | John D. Walter |
| | Robert J. Becker | Albert W. Ray, Jr. |
| WILLIAMSON | Herbert V. Fine | Renato Katubig |
| WINNEBAGO (5) | Robert Behmer | R. Glenn Smith |
| | Eugene T. Leonard | George C. Green |
| | F. H. Riordan, III | Richard C. Webb |
| | Harry Darland | H. Clifford Carlson, Jr. |
| | Joseph B. Perez | |
| WOODFORD | Ronald Meyers | Robert Lykkebak |
| STUDENTS | David Hopp | John Johnson |
| HOUSESTAFF | Robert L. Cavens | Linda Hughey |

# Cook County Delegates

| *Delegates* | *Alternate Delegates* | *Delegates* | *Alternate Delegates* |
|---|---|---|---|
| Aaronson, Donald | Ahstrom, James, Jr. | Murray, Meredith B. | Munoz, Maria |
| Ackley, William O. | Ashley, William F. | Naunton, Ralph | Murphy, Thomas E. |
| Andelman, Samuel L. | Banich, Francis E. | Nemecek, Raymond W. | Mustell, Robert R. |
| Andersen, James H. | Banuchi, Fedor F. | Neskodny, J. F. | Nainis, William S. |
| Blankshain, Richard | Barber, Frederick | Norberg, Clarence A. | Nikurs, Lydia |
| Brislen, Andrew J. | Beck, Charles A. | O'Brien, James C. | Odiaga-Garcia, Ignacio |
| Brown, Finley W. Jr. | Berg, Max | O'Donnell, John W. | Olivar, Adriano S. |
| Budrys, Stanley | Bild, Sidney | Okner, Henry B. | Olivieri, Ernest P. |
| Burkhead, Howard C. | Bogen, Gilbert | Palumbo, Carl F. | O'Sullivan, Donal D. |
| Chamberlain, Danford O. | Borden, Nicholas J. | Patlak, Erwin M. | Panayotou, Irene |
| Ciskoski, Roland J. | Borelli, Nelson | Peterson, Arthur R. | Pantone, Anton M. |
| Costanzo, Vincent A. | Branovacki, Eugene | Petty, David T. | Paull, Murry M. |
| Cross, Roland R. | Buinauskas, Peter | Quinlan, Donald | Pedroso, Aldo F. |
| Czeisler, Tibor | Burdick, Allison L., Jr. | Razim, Edward A. | Perritt, Richard A. |
| Des Rosiers, Raymond J. | Burdick, Allison L., Sr. | Reeder, Clifton L. | Pill, Michael P. |
| Falloon, Edwin L. | Burke, Edward A. | Rice, C. Malcolm Jr. | Pleotis, Peter |
| Filipowicz, Roman I. | Cermak, Miles | Romanus, Raymond J. | Poma, Pedro A. |
| Fish, William | Chaljub, Najib | Rothstein, David A. | Prombo, Marjorie P. |
| FitzGibbons, James P. | Christensen, Eldis M. | Ruiz, Gonzalo | Pruc, Jeremias N. |
| Flaherty, Bernard P. | Colbert, Maurice | Ruzich, Stanley | Rebendel, Marek B. |
| Frankel, Jerome J. | Constantaras, Alexander | Sarley, Vincent C. | Rogin, Alan |
| Freda, Vincent C. | De La Mata, Augustin | Saxena, Virendra S. | Rosenzweig, Oscar |
| Freidheim, Jere | De Rose, William F. | Schimel, Samuel J. | Rowlette, Raymond S. |
| Friedell, Morris T. | De Trana, Frank A. | Sedlak, Frank | Roy, Shirley |
| Friefeld, Nathan | De Young, Willard G. | Shapiro, Maynard I. | Ruane, Michael |
| Gertz, George | Diaz, Alfonso | Shobris, Martin | Saltiel, Isaac |
| Green, Martin W. | Diffenbaugh, Willis G. | Sinaiko, Edwin S. | Schifano, Joseph |
| Guerrero, Severo K., Jr. | Farah, George S. | Smith, C. Otis | Schwartz, Franklin |
| Hamilton, Robert C. | Forman, Max | Smith, William | Schuetz, John N. |
| Harrod, John P., Jr. | Gardner, Philip M. | Soboroff, Burton J. | Scruggs, Charles |
| Hinkamp, Joseph F. | Gau, Frederick | Solon, Earl N. | Seed, Randolph W. |
| Horton, Loren B. | Gnade, Gerard R. | Sperling, Richard L. | Seskind, Coleman R. |
| Hrejsa, Allen C. | Goldstein, Henry A. | Staley, Warren H. | Singh, Nerissa P. |
| Hussey, Frank L., Sr. | Graham, James F. | Suckow, Earl E. | Spinka, Harold |
| Hutchison, William A. | Gross, Alvin | Sugar, Sam J. | Springer, Harry A. |
| Hyde, John S. | Gurney, Clifford W. | Tansey, William J. | Stopka, John E. |
| Jacobs, W. Francis | Handler, Jerome L. | Thompson, J. Robert | Strohl, Lee H. |
| Jirka, Frank J., Jr. | Head, Louis | Tovar, Jorge | Surath, Vasanth M. |
| Joslyn, A. Everett, Jr. | Hollett, Alan M. | Treister, Michael R. | Swartz, Robert M. |
| Kalsch, Harry E. | Hussey, Frank L., Jr. | Turner, George C. | Talso, Peter J. |
| Kaz, Alex H. | Jaffe, Harry J. | Tworoger, Fred A. | Thampy, Kishore J. |
| Kirschenbaum, M. Barry | John, Thomas | Walkowiak, Lydia | Thrasher, Irving D. |
| Kowal, Roland A. | Jones, Richard | Waller, Jesse E. | Tsatsos, George |
| Kozak, John A. | Kass, Harold M. | Weigel, Charles J. | Ungar, Jacob |
| Kunis, Arthur | Kerr, William D. | Weingarten, Charles Z. | Urban, Conrad J. |
| Kwinn, Frank C. | Kobak, Mathew W. | Williams, Jack | Wehrmacher, William H. |
| Lagorio, George L. | Koch, Donald | Xydakis, Stephanos A. | Zitek, Russell W. |
| Lobraico, Rocco V., Jr. | Krolikowski, John R. | Yanex, Frank | |
| Lounsbury, B. Franklin | Landau, Richard L. | Yatvin, Harold | |
| MacNerland, Robert H. | Lipsich, Michael | | |
| Marcus, Anna A. | Lucina, Pedro A. | | |
| Markoutsas, George C. | Mahler, Sandra | | |
| Marshall, William | McCabe, Mary Joan | | |
| Mehlinger, Kermit T. | Mella, Luis | | |
| Meisenheimer, Martin P. | Mikhail, Kamel A. | | |
| Moles, Joseph B. | Muehrcke, Robert C. | | |

# Officers of County Medical Societies
# 1978

| County | President | Secretary |
|---|---|---|
| Adams<br>Members: 93-Dist. 6<br>Maxine Boyer, Ex. Sec.<br>1118 Broadway<br>Quincy 62301 | Guenter Gehrich<br>1101 Maine, Quincy 62301 | Richard L. Newman<br>1124 Broadway, Quincy 62301 |
| Alexander<br>Members: 9-Dist. 9 | Gemo Wong<br>2020 Cedar, Cairo 62914 | Charles L. Yarbrough<br>800 Commercial, Cairo 62914 |
| Bond<br>Members: 9-Dist. 7 | M. Kenneth Kaufmann<br>105 E. College, Greenville 62246 | John K. Dawdy<br>404 Forest Lane, Greenville 62246 |
| Boone<br>Members: 20-Dist. 12 | Maurice J. Carlisle<br>115 W. Lincoln, Belvidere 61008 | John Steinkamp<br>824 S. Van Buren, Belvidere 61008 |
| Bureau<br>Members: 35-Dist. 2 | James Foresman<br>204 Park Ave., Princeton 61356 | Donald M. Gallagher<br>Box 538, Granville 61326 |
| Carroll<br>Members: 7-Dist. 12 | Basilios Lambos<br>North 4th Street, Savannah 61074 | Tadeusz Maciejczyk<br>Milledgeville 61051 |
| Cass-Brown<br>Members: 2-Dist. 6 | R. A. Spencer<br>115 W. 4th St., Beardstown 62618 | B. A. DeSulis<br>115 W. 4th St., Beardstown 62618 |
| Champaign<br>Members: 216-Dist. 8<br>Larry Booth, Ex. Sec.<br>1408 W. University<br>Urbana, 61801 | Richard B. Helfrich<br>602 W. University, Urbana 61801 | H. Ewing Wachter<br>2108 W. Springfield, Champaign 61820 |
| Christian<br>Members: 25-Dist. 7 | E. Doyle Slifer<br>201 E. Pleasant St., Taylorville 62568 | I. Del Valle<br>311 S. Main, Taylorville 62568 |
| Clark<br>Members: 7-Dist. 8 | Howard G. Johnson<br>Casey Medical Center, Casey 62420 | Eugene P. Johnson<br>P.O. Box 68, Casey 62420 |
| Clay<br>Members: 7-Dist. 7 | A. Paul Naney<br>Flora Clinic, Flora 62839 | Donald L. Bunnell<br>Flora Clinic, Flora 62839 |
| Clinton<br>Members: 11-Dist. 7 | James A. Kirby<br>401 N. Main, Breese 62230 | Robert D. Roane<br>1131 Fairfax St., Carlyle 62231 |
| Coles-Cumberland<br>Members: 44-Dist. 8 | H. C. Lin<br>1700 Wabash Ave., Mattoon 61938 | Asit P. Basu<br>501 Jackson Ave., Charleston 61920 |
| Cook<br>Members: 8570-Dist. 3<br>Robert Lindley, Ex. Adm.<br>310 S. Michigan Ave.<br>Chicago 60604 | Morris T. Friedell<br>7531 S. Stony Island, Chicago 60649 | B. Franklin Lounsbury<br>707 N. Fairbanks, Chicago 60611 |
| Crawford<br>Members: 15-Dist. 8 | Thomas P. Sloan<br>Schmidt Clinic, Robinson 62454 | W. B. Schmidt<br>Schmidt Clinic, Robinson 62454 |
| De Kalb<br>Members: 58-Dist. 12 | Frank E. Luedtke<br>235 S. Third St., DeKalb 60115 | Loren W. Akers<br>Northern Ill. Univ., DeKalb 60115 |
| De Witt<br>Members: 11-Dist. 5 | John W. Veirs<br>219 E. Main, Clinton 61727 | C. N. Radhakrishna<br>210 E. Main, Clinton 61727 |
| Douglas<br>Members: 8-Dist. 8 | Walter Steiner<br>140 W. Sale Street, Tuscola 61953 | Humberto Mondul<br>111 W. South Central, Tuscola 61953 |
| Du Page<br>Members: 595-Dist. 11<br>Lillian Widmer, Ex. Sec.<br>26 W. St. Charles Rd.<br>Lombard, IL 60148 | Thomas W. Stach<br>120 Oakbrook Center Mall,<br>Oak Brook 60521 | James P. Campbell<br>322 N. Blanchard St., Wheaton 60187 |

| County | President | Secretary |
|---|---|---|
| Edgar<br>Members: 17-Dist. 8 | J. R. Shackelford<br>502 Shaw, Paris 61944 | J. M. Ingalls<br>Medical Center Clinic, Paris 61944 |
| Edwards<br>Members: 3-Dist. 9 | Paul S. Neirenberg<br>7 W. Main, Albion 62806 | Andrew Krajec<br>108 W. South St., West Salem 62476 |
| Effingham<br>Members: 23-Dist. 7 | Yong Lee<br>602 Park Hills, Effingham 62401 | Fabio H. Mota<br>300 N. Maple, Effingham 62401 |
| Fayette<br>Members: 7-Dist. 7 | D. H. Rames<br>1029 N. 8th, Vandalia 62471 | Hans Rollinger<br>1003 N. 8th St., Vandalia 62471 |
| Ford<br>Members: 13-Dist. 11 | William A. Garrett<br>Sibley 61773 | Paul W. Sunderland<br>214 N. Sangamon, Gibson City 60936 |
| Franklin<br>Members: 29-Dist. 9 | James P. Durham<br>Benton Med. Clinic, Benton 62812 | D. P. Richerson<br>P.O. Box 99, Christopher 62822 |
| Fulton<br>Members: 31-Dist. 4 | Marvin E. Schmidt<br>Graham Hospital, 210 W. Walnut,<br>Canton 61520 | Marcos A. Arancibia<br>Graham Hospital<br>210 W. Walnut, Canton 61520 |
| Gallatin<br>Members: 2-Dist. 9 | | John E. Doyle<br>Ridgway 62979 |
| Greene<br>Members: 6-Dist. 6 | Jude A. Caselton<br>9th St., Carrollton 62016 | James C. Reid<br>Fillager Mem. Clinic, Greenfield 62044 |
| Hancock<br>Members: 12-Dist. 4 | Vasant Pawar<br>Memorial Hospital, Carthage 62321 | James E. Coeur<br>630 Locust, Carthage 62321 |
| Henderson<br>Members: 1-Dist. 4 | Silvino Lindo, Jr.<br>Biggsville 61418 | |
| Henry-Stark<br>Members: 37-Dist. 4 | Roberto S. Puentes<br>100 E. Main, Geneseo 61254 | Donald R. Ford<br>648 N. Chicago St., Geneseo 61254 |
| Iroquois<br>Members: 19-Dist. 11 | David C. Christy<br>Watseka 60970 | Y. S. Song<br>P.O. Box V348, Watseka 60970 |
| Jackson<br>Members: 61-Dist. 9 | Roger N. Klam<br>Box 2347, Carbondale 62901 | Steven A. Nagel<br>404 W. Main Street, Carbondale 62901 |
| Jasper<br>Members: 2-Dist. 8 | Don L. Hartrich<br>1211 W. Jourdan, Newton 62448 | Monico Low<br>609 S. Van Buren, Newton 62448 |
| Jefferson-Hamilton<br>Members: 34-Dist. 9 | Prince B. Oliver<br>Post Office Box 1001, Mt. Vernon 62864 | Kenneth A. Peart<br>Doctors Park, Mt. Vernon 62864 |
| Jersey-Calhoun<br>Members:12-Dist. 6 | S. S. Kurella<br>McDow Med. Cntr., Maple Summit Rd.,<br>Jerseyville 62052 | Bernard Baalman<br>Medical Center, Hardin 62047 |
| Jo Daviess<br>Members: 8-Dist. 12 | William Gillies<br>300 Summit St., Galena 61036 | David Hockman<br>300 Summit St., Galena 61036 |
| Kane<br>Members: 307-Dist. 1<br>Michael Wild, Ex. Dir.<br>11 S. 2nd St.<br>Geneva 60134 | Charles K. Bobelis<br>860 Summit, Elgin 60120 | James R. Downing<br>157 S. Lincoln, Aurora 60505 |
| Kankakee<br>Members: 103-Dist. 11 | Morris Lang<br>1309 E. Court St., Kankakee 60901 | Charles F. Lind<br>500 W. Court St., Kankakee 60901 |
| Kendall<br>Members: 7-Dist. 11 | Walter Brill<br>Main St., Oswego 60543 | John P. Cullinan<br>Oswego 60543 |
| Knox<br>Members: 74-Dist. 4 | Robert G. Hickerson, Jr.<br>309 E. Main, Knoxville 61448 | J. John Loesch<br>Galesburg Cottage Hosp., Galesburg 61401 |
| Lake<br>Members: 364-Dist. 1<br>Julia Schulz, Ex. Sec.<br>P.O. Box 148<br>Gurnee, Ill. 60031 | Joseph L. Burke<br>2504 Washington St., Waukegan 60085 | James R. Creath<br>2504 Washington St., Waukegan 60085 |

| County | President | Secretary |
|---|---|---|
| LaSalle<br>Members: 110-Dist. 2 | Mavis Schraudenbach<br>24 Stacy, Streator 61364 | Allan L. Goslin<br>712 N. Bloomington, Streator 61364 |
| Lawrence<br>Members: 9-Dist. 8<br>Ruth Gariepy, Ex. Sec.<br>Lawrence Cty. Mem. Hosp.<br>Lawrenceville 62439 | Robert J. Nichols<br>P.O. Box 907, Vincennes, Ind. 47591 | Alexander Po<br>R.R. #2, Lawrenceville 62439 |
| Lee<br>Members: 29-Dist.12 | George S. Silvest<br>White Oaks, R.R. 3, Dixon 61021 | Tiam H. Lie<br>Castellan, R.R. 5, Dixon 61021 |
| Livingston<br>Members: 29-Dist. 2 | John C. Purnell<br>401 E. Water St., Pontiac 61764 | Karl T. Deterding<br>612 E. Water, Pontiac 61764 |
| Logan<br>Members: 26-Dist. 5 | Glen Tomlinson<br>#4 Doctor's Park, Lincoln 62656 | Robert Brown Perry<br>523 N. Elm, Lincoln 62656 |
| Macon<br>Members: 157-Dist. 7<br>Mary J. Bretz, Ex. Sec.<br>1800 E. Lake Shore Dr.<br>Decatur 62521 | Paul R. Stanley<br>418 W. Wood, Decatur 62522 | Joseph Schrodt<br>363 S. Main, Decatur 62523 |
| Macoupin<br>Members: 21-Dist. 6 | Jose K. Villegas<br>Physicians Bldg., Carlinville 62626 | Robert England<br>224 E. Main, Carlinville 62626 |
| Madison<br>Members: 178-Dist. 6 | Melvin Freedman<br>2025 Edison Ave., Granite City 62040 | Norman E. Taylor<br>95 S. 9th St., E. Alton 62024 |
| Marion<br>Members: 39-Dist. 7 | Hahmid Mahmud<br>111 E. Rogers, Salem 62881 | W. P. Plassman<br>Box 552, Centralia 62801 |
| Mason<br>Members: 6-Dist. 5 | Henry W. Maxfield<br>315 E. Chestnut, Mason City 62664 | |
| Massac<br>Members 3-Dist. 9 | | Benito Bajuyo<br>710 Catherine St., Metropolis 62960 |
| McDonough<br>Members: 35-Dist. 4 | Kenneth T. Pawlias<br>501 E. Grant, Macomb 61455 | David Reem<br>505 E. Grant, Macomb 61455 |
| McHenry<br>Members: 82-Dist. 1<br>Evelyn Rosulek, Ex. Sec.<br>308 E. Kimball<br>Woodstock 60098 | Aniceto M. D'Sousa<br>1110 Green St., McHenry 60050 | Ted L. Rolander<br>1110 N. Green St., McHenry 60050 |
| McLean<br>Members: 116-Dist. 5<br>Bernyce Carbery<br>Exec. Sec.<br>401 W. Virginia<br>Normal 61761 | Robert Knight<br>6 Citizens Square, Normal 61761 | Douglas R. Bey<br>900 Franklin Ave., Normal 61761 |
| Mercer<br>Members: 6-Dist. 4 | Monty P. McClellan<br>309 NW 2nd St., Aledo 61231 | James W. Hastings<br>301 NW 2nd St., Aledo 61231 |
| Monroe<br>Members: 9-Dist. 10 | Edilberto F. Maglasang<br>109 W. Legion, Columbia 62236 | Chung H. Khan<br>Route 1, Maeystown Rd., Waterloo 62298 |
| Montgomery<br>Members: 22-Dist. 5 | Calixto F. Aquino, Jr.<br>112 W. Kirkham St., Litchfield 62056 | James T. Foster<br>8 Arrowhead Rd., Litchfield 62056 |
| Morgan-Scott<br>Members: 48-Dist. 6 | A. George Schultz<br>2000 W. Morton, Jacksonville 62650 | James Veenstra<br>Passavant Memorial Hospital<br>1600 W. Walnut St., Jacksonville 62650 |
| Moultrie<br>Members: 5-Dist.-7 | Phillip Best<br>14 N. Washington, Sullivan 61951 | Dean McLaughlin<br>112 E. Harrison, Sullivan 61951 |

| County | President | Secretary |
|---|---|---|
| Ogle<br>Members: 15-Dist. 12 | L. T. Koritz<br>324 Lincoln, Rochelle 61068 | Russell Zack<br>915 Caron, Rochelle 61068 |
| Peoria<br>Members: 332-Dist. 4<br>M. John Hanni, Jr., Ex. Sec.<br>427 1st National Bank<br>Peoria 61602 | Lorris Bowers<br>427 1st Nat'l. Bank Bldg., Peoria 61602 | Henry Boldt<br>427 1st Nat'l. Bank Bldg., Peoria 61602 |
| Perry<br>Members: 15-Dist. 10 | Gene Stotlar<br>13 N. Walnut St., Pinckneyville 62274 | Bill R. Fulk<br>207 E. Main, DuQuoin 62832 |
| Piatt<br>Members: 5-Dist. 7 | George Green<br>121 N. State, Monticello 61856 | Joseph Allman<br>121 N. State, Monticello 61856 |
| Pike<br>Members: 10-Dist. 6 | Ansar H. Ansari<br>203 N. Madison, Pittsfield 62363 | T. C. Bunting<br>321 W. Washington, Pittsfield 62363 |
| Pulaski<br>Members: 1-Dist. 9 | A. L. Robinson<br>Box 277, Mounds 62964 | |
| Randolph<br>Members: 21-Dist. 10 | Vinai Navapant<br>818 E. Broadway, Sparta 62286 | C. S. Schlageter<br>818 E. Broadway, Sparta 62286 |
| Richland<br>Members: 25-Dist. 8 | Michael E. Murray<br>1200 N. East, Olney 62450 | Peter C. Weber<br>1200 N. East, Olney 62450 |
| Rock Island<br>Members: 204-Dist. 4<br>James A. Koch, Ex. Sec.<br>612 Kahl Bldg.<br>Davenport, Iowa 52801 | James P. Johnston<br>1630 5th Ave., Moline 61265 | E. D. Lardner<br>3637 23rd Ave., Moline 61265 |
| St. Clair<br>Members: 250-Dist. 10<br>Ed Belz, Ex. Sec.<br>4825 W. Main<br>Belleville 62223 | Donald L. Jerome<br>6401 W. Main, Belleville 62223 | Paul Rusnack<br>St. Elizabeth's Hosp., Belleville 62220 |
| Saline-Pope-Hardin<br>Members: 33-Dist. 9 | Vinay K. Mehta<br>203 N. Vine, Harrisburg 62946 | Warren R. Dammers<br>P.O. Box 281, Harrisburg 62946 |
| Sangamon<br>Members: 313-Dist. 5<br>L. R. Brosi, Ex. Dir.<br>1 N. Old State Capitol Plaza,<br>Springfield 62701 | Edward G. Ference<br>932 S. 2nd St., Springfield 62704 | Towfig Arjmand<br>1209 S. Fourth, Springfield 62704 |
| Schuyler<br>Members: 4-Dist. 4 | R. R. Dohner<br>103 W. Washington, Rushville 62681 | Henry C. Zingher<br>West Side Square, Rushville 62681 |
| Shelby<br>Members: 8-Dist. 7 | Theodore Little<br>207 S. Pine, Shelbyville 62565 | Otto G. Kauder<br>P.O. Box 225, Shelbyville 62565 |
| Stephenson<br>Members: 51-Dist. 12 | Edward Maglietta<br>1036 W. Stephenson, Freeport 61032 | Karl Schwiesow<br>220 W. Exchange, Freeport 61032 |
| Tazewell<br>Members: 53-Dist. 5<br>Colleen Ingersoll,<br>Exec. Sec.<br>P.O. Box 778<br>Pekin 61554 | Robert L. Tucker<br>P.O. Box 778, Pekin 61554 | Daniel L. Parr<br>P.O. Box 778, Pekin 61554 |
| Union<br>Members: 10-Dist. 9 | Robert L. Rader<br>200 N. Main St., Anna 62906 | William H. Whiting<br>525 N. Main, P.O. Drawer 559, Anna 62906 |
| Vermilion<br>Members: 97-Dist. 8 | Edmund G. Andracki<br>120 S. Main, Georgetown 61846 | L. W. Tanner<br>7 N. Virginia, Danville 61832 |
| Wabash<br>Members: 6-Dist. 9 | T. R. Young<br>512 Market St., Mt. Carmel 62863 | C. L. Johns<br>114 W. 5th St., Mt. Carmel 62863 |

| County | President | Secretary |
|---|---|---|
| Warren<br>Members: 13-Dist. 4 | James Marshall<br>319 N. Main, Monmouth 61462 | Glenn W. Chamberlin<br>219 E. Euclid, Monmouth 61462 |
| Washington<br>Members: 6-Dist. 10 | Charles Longwell<br>111 S. Washington, Nashville 62263 | Jerry L. Beguelin<br>Box 197, Irvington 62848 |
| Wayne<br>Members: 7-Dist. 9 | S. W. Konarski<br>101 E. Center, Fairfield 62837 | E. Loftin<br>301 N.W. 11th, Fairfield 62837 |
| White<br>Members: 8-Dist. 9 | William Courtnage<br>Carmi Med. Cntr., Carmi 62821 | Morris McCall<br>South Plum St., Carmi 62821 |
| Whiteside<br>Members: 50-Dist. 12 | Timothy Sullivan, Jr.<br>1716 Locust, Sterling 61081 | Carmelo Interone<br>14 E. Miller Rd., Sterling 61081 |
| Will-Grundy<br>Members: 232-Dist. 11<br>Ronald W. Batozech, Ex. Sec.<br>3033 W. Jefferson<br>Suite 220<br>Joliet 60435 | Archibald D. McCoy<br>57 W. Jefferson, Joliet 60431 | Robert L. Kleinhoffer<br>1415 Maple Rd., Joliet 60432 |
| Williamson<br>Members: 35-Dist. 9 | David L. Sloan<br>Herrin Hosp., Herrin 62948 | Herbert V. Fine<br>110 N. Division, Carterville 62918 |
| Winnebago<br>Members: 389-Dist. 12<br>Mrs. Johanna Lund<br>Exec. Adm.<br>310 N. Wyman St.<br>Rockford 61101 | George C. Green<br>4120 Charles St., Rockford 61108 | Bernard O'Malley<br>5670 E. State St., Rockford 61108 |
| Woodford<br>Members: 7-Dist. 2 | K. Vaicius<br>511 Oak, Minonk 61760 | James W. Riley<br>109 S. Major, Eureka 61530 |

**No Organized County Society**

Johnson
Marshall
Menard
Putnam

**Joint County Societies**

Cass-Brown
Coles-Cumberland
Henry-Stark
Jefferson-Hamilton
Jersey-Calhoun
Morgan-Scott
Saline-Pope-Hardin
Will-Grundy

---

The Illinois State Medical Society has developed the council and committee structure to facilitate the activities and responses of its members. Council and committee members are selected annually, based on suggestions and nominations of trustees, delegates, and county medical societies. Appointments are made by the Chairman of the Board of Trustees, with approval of the Board.

Please notify your trustee if you wish to be considered for appointment. The various activities are as listed in the Reference Issue (October). Members who wish to notify Chairman of the Board of their availability can clip and submit the coupon below.

NAME: _____

ADDRESS: _____ CITY: _____ ZIP: _____

TELEPHONE: ( ) _____

COUNTY MEDICAL SOCIETY: _____

MEDICAL SPECIALTY AND TYPE OF PRACTICE _____

COMMITTEE IN WHICH INTERESTED: _____

EXPERTISE FOR THIS COMMITTEE: _____

SEND TO: Chairman, Board of Trustees, Illinois State Medical Society
55 E. Monroe, Suite 3510, Chicago, IL 60603

# *Agenda*

# *1978 House of Delegates*

Cyril C. Wiggishoff, M.D. *Speaker*

Robert P. Johnson, M.D., *Vice-Speaker*

## FIRST SESSION

**1:00 p.m.—Sunday, April 2, 1978**
**Red Lacquer Room**
**Palmer House**
**Chicago**

1. Call to order
   Cyril C. Wiggishoff, M.D., *Speaker*
2. Invocation
3. Report of Committee on Rules and Order of Business
4. Report of Credentials Committee
5. Approval of minutes of previous meeting
6. Memorial Service for deceased members since April, 1977, conducted by Eugene P. Johnson, M.D., *Secretary-Treasurer*
7. Report of Chairman, Board of Trustees
   Robert T. Fox, M.D.
8. Remarks of Speaker
9. Resolutions and supplementary reports
10. New business and announcements
    Reference Committees—2:00 p.m.
    Delegates' Buffet—6:30 p.m.
11. Recess until 2:00 p.m.—Monday, April 3, 1978

## SECOND SESSION

**2:00 p.m.—Monday, April 3, 1978**
**Red Lacquer Room**
**Palmer House**
**Chicago**

1. Call to order by speaker
2. Report of Committee on Rules and Order of Business
3. Report of Credentials Committee
4. Reports of special guests
   Mrs. Edward Szewczyk, *President,* Illinois State Medical Society Auxiliary
   Mrs. Vivian Kraft, *President,* Illinois Society, American Association of Medical Assistants
5. Introduction of special guests
6. Presentation of Continuing Medical Education Awards
7. Presentation of AMA-ERF check to Illinois medical schools
8. IMPAC Report
   Mrs. Alan Taylor, *Chairman*
9. Report of Executive Administrator
   Mr. Roger N. White
10. Introduction of AMA Delegates and Alternate Delegates
    Jack Gibbs, M.D., *Chairman*
11. President's Address
    George T. Wilkins, Jr., M.D.
12. New business and announcements
13. Recess until 9:00 a.m.—Tuesday, April 4, 1978

# THIRD SESSION

## 9:00 a.m.—Tuesday, April 4, 1978

## Red Lacquer Room
## Palmer House
## Chicago

1. Call to order by the speaker
2. Invocation
3. Report of Committee on Rules and Order of Business
4. Report of Credentials Committee
5. Announcements and introduction of guests
6. Reports of Reference Committees
   - Amendments to Constitution and Bylaws
   - Committee A—Officers, Administration, Finances and Budgets
   - Committee B—Government Health Programs, including National Health Insurance and Cost Containment
   - Committee C—Education, Manpower and Clinical Medicine
   - Committee D—Medical Service and Economic Matters Outside of Government Programs
   - Committee E—Governmental Affairs and Medical Legal
   - Committee F—Public Relations, Membership and Miscellaneous Business
7. Recess for luncheon
8. Reconvene 2:15 p.m.
9. New Business
10. Recess until 8:30 p.m.—Tuesday, April 4, 1978 (if necessary)
11. Recess until 9:00 a.m.—Wednesday, April 5, 1978

# FOURTH SESSION

## 9:00 a.m.—Wednesday, April 5, 1978

## Red Lacquer Room
## Palmer House
## Chicago

1. Call to order by the Speaker
2. Invocation
3. Report of Committee on Rules and Order of Business
4. Report of Credentials Committee
5. Induction of David S. Fox, M.D., President-Elect, into office of President by George T. Wilkins, Jr., M.D.
6. Address of President Fox
7. Announcements and introduction of guests
8. Reports of reference committees
9. Elections
   - Report of Nominating Committee
     - (a) President-Elect (DS)
     - (b) 1st Vice President (CMS)
     - (c) 2nd Vice President (DS)
     - (d) Secretary-Treasurer
     - (e) Speaker of the House (CMS)
     - (f) Vice Speaker (DS)
     - (g) Trustees

| *DISTRICT* | *TERMS EXPIRING* |
|---|---|
| First | John Ring, M.D. |
| Third | Jere Freidheim, M.D. |
| Third | Eugene T. Hoban, M.D. |
| Third | Henrietta Herbolsheimer, M.D. |
| Third | Lawrence L. Hirsch, M.D. |
| Third | Harold J. Lasky, M.D. |
| Sixth | Robert R. Hartman, M.D. |
| Ninth | Warren D. Tuttle, M.D. |
| Tenth | Julian Buser, M.D. |

   - (h) Delegates to AMA to take office January 1, 1979 and serve until December 31, 1980

*Terms Expiring*

Allison Burdick, Jr., M.D.
Alfred J. Faber, M.D.
David S. Fox, M.D.
Lawrence L. Hirsch, M.D.
Joseph R. O'Donnell, M.D.
John J. Ring, M.D.
Charles K. Wells, M.D.

   - (i) Alternate Delegates to AMA to take office on January 1, 1979 and serve until December 31, 1980.

*Terms Expiring*

Audley F. Connor, Jr., M.D.
Morris Friedell, M.D.
Henrietta Herbolsheimer, M.D.
Fredric D. Lake, M.D.
Eugene T. Leonard, M.D.
Robert P. Johnson, M.D.

10. Fixing of per capita dues for 1979
11. Selection of meeting place and time for next meeting
12. Unfinished business
13. New business
14. Adjournment, Sine Die

# Committees of the House of Delegates

# 1978 Annual Meeting

## COMMITTEE ON RULES & ORDER OF BUSINESS

This committee shall consider all matters regarding rules governing actions, methods and procedure, and the order of business (agenda) for the session of the House of Delegates. It shall work in close cooperation with the Speaker and Vice Speaker.

The committee shall contact the Speaker just prior to each session of the House to make sure that all recommendations for House action are included in its report.

## COMMITTEE ON CREDENTIALS

This committee shall consider all questions regarding the registration and certification of delegates. The chairman shall keep the Speaker of the House informed of the voting power thereof.

The committee shall distribute and receive the attendance slips and perform such other duties as may be assigned by the Speaker.

This committee shall meet at least one hour prior to the opening session of the House and one-half hour prior to the opening of the other sessions.

## TELLERS AND SERGEANTS AT ARMS

This committee shall serve the Speaker of the House of Delegates whenever a vote count is called for, whenever a ballot is scheduled, or the House goes into executive session.

## REFERENCE COMMITTEE ON AMENDMENTS TO CONSTITUTION & BYLAWS

This committee shall consider and report to the House of Delegates its recommendations on all proposed amendments to the Constitution and Bylaws.

## REFERENCE COMMITTEE A

This committee shall consider and submit its recommendations to the House of Delegates upon reports and resolutions relating to officers, administration, finances and budgets.

## REFERENCE COMMITTEE B

This committee shall consider and submit its recommendations to the House of Delegates upon reports and resolutions relating to government health programs, including national health insurance and cost containment.

## REFERENCE COMMITTEE C

This committee shall consider and submit its recommendations to the House of Delegates upon reports and resolutions relating to education, manpower and clinical medicine.

## REFERENCE COMMITTEE D

This committee shall consider and submit its recommendations to the House of Delegates upon reports and resolutions relating to medical service and economic matters outside government programs.

## REFERENCE COMMITTEE E

This committee shall consider and submit its recommendations to the House of Delegates upon reports and resolutions relating to governmental affairs and medical legal matters.

## REFERENCE COMMITTEE F

This committee shall consider and submit its recommendations to the House of Delegates upon reports and resolutions relating to public relations, membership and miscellaneous business.

# Program Summary By Days

## ISMS Annual Meeting

April 1-5, 1978 — Palmer House, Chicago

### Saturday
### April 1, 1978

| | |
|---|---|
| 10:00 a.m. | Resident Physician Section |
| 12:00 noon | ISMS Board of Trustees Luncheon |
| 1:00 p.m. | Student Business Session |
| 1:30 p.m. | ISMS Board of Trustees Meeting |
| 5:30 p.m. | ISMS Board of Trustees Reception & Dinner |
| 7:30 p.m. | ISMS Board of Trustees Meeting |

### Sunday
### April 2, 1978

| | |
|---|---|
| 8:00 a.m. | Registration |
| 9:30 a.m. | Meeting of Reference Committee Members |
| 10:15 a.m. | District Meetings |
| 12:00 noon | Credentials Committee |
| 1:00 p.m. | House of Delegates |
| 2:00 p.m. | Reference Committees |
| 6:00 p.m. | University of Illinois Medical Alumni Dinner |
| 6:30 p.m. | Delegates Buffet |

### Monday
### April 3, 1978

| | |
|---|---|
| 7:30 a.m. | CIMA Breakfast |
| 7:30 a.m. | Board of Trustees Breakfast |
| 7:30 a.m. | Preventive Medicine Breakfast |
| 8:00 a.m. | Registration |
| 8:30 a.m. | Alcoholism Workshop |
| 9:00 a.m. | ICCME Workshop |
| 10:00 a.m. | ISMIE Annual Meeting |
| 11:00 a.m. | ISMIE Board of Governors Reorganization Meeting |
| 11:30 a.m. | Fifty Year Club Luncheon |
| 2:00 p.m. | House of Delegates |
| 3:45 p.m. | IMPAC Annual Meeting |
| 4:15 p.m. | Downstate Caucus |
| 4:15 p.m. | C.M.S. Caucus |
| 6:00 p.m. | President's Night & 50th Anniversary of ISMS Auxiliary—Reception and Dinner |

### Tuesday
### April 4, 1978

| | |
|---|---|
| 7:30 a.m. | CIMA Breakfast |
| 7:30 a.m. | Board of Trustees Breakfast |
| 9:00 a.m. | House of Delegates |
| 9:00 a.m. | Illinois Society of Pathology |
| 9:00 a.m. | Seminar: Establishing Yourself in Private Practice |
| 11:45 a.m. | Public Affairs Luncheon<br>IMPAC Workshop immediately following |
| 12:00 noon | Illinois Society of Pathology Luncheon |
| 2:15 p.m. | House of Delegates |
| 8:30 p.m. | House of Delegates (if necessary) |

### Wednesday
### April 5, 1978

| | |
|---|---|
| 7:30 a.m. | Board of Trustees Breakfast |
| 7:30 a.m. | CIMA Breakfast |
| 8:00 a.m. | Registration |
| 9:00 a.m. | House of Delegates<br>Board of Trustees Reorganization Meeting immediately following House Adjournment |

**CALLS WILL REACH YOU EASILY AT THE 1978 CONVENTION**

Doctor, please inform your staff that while you are attending the ISMS convention, you may be reached through the Physician's Message Center, open April 2-5, 9:00 a.m. to 4:30 p.m.

**312-376-1751**

This is a direct connection which will not go through the hotel switchboard.

# 50th Annual Meeting Program
# ISMS Auxiliary
# Palmer House, Chicago

## Sunday, April 2

| | | |
|---|---|---|
| **11:30** | Pin and Gavel Luncheon (Past Presidents Only)<br>*Drake Hotel, Venetian Room* | |
| **2:00-4:00** | Registration | *Sixth Floor* |
| **3:30** | Pre-Convention Board Meeting | *Chicago Room* (lower level) |
| **5:30** | Board Dinner (Guests) | *Luau Room* (lower level) |
| **8:30** | Reception honoring Members-at-Large | *Hospitality Suite* |

## Monday, April 3: "Auxiliary Yesterday"

| | | |
|---|---|---|
| **9:00-5:00** | Registration | *Sixth Floor* |
| **9:30** | Opening Session—House of Delegates<br>Welcome—*Mrs. Jack Clemis, President, CMS Auxiliary*<br>Response—*Mrs. H. Frank Holman, Convention Chairman*<br>Pledge—*Mrs. Earl Klaren, President-Elect*<br>Introduction of Special Guests—*Mrs. R. S. Hoover*<br>Greetings from ISMS Officers<br>Introduction of Keynote Speaker—*Mrs. Willard Scrivner*<br>Keynote Address—*Mrs. Chester Young, President AMAA*<br>Business<br>Memorial Service—*Mrs. Wendell Roller* | *Adams Room* |
| **1:00 p.m.** | President's 50th Anniversary Luncheon<br>Honoring Past Presidents (Guests)<br>"Motivation"—*Marilyn Van Derbur, Miss America 1958* | *Monroe Room* |
| | Afternoon open for viewing of displays and voting | |
| **6:00** | ISMS President's Night honoring George T. Wilkins, Jr., M.D., and ISMS Auxiliary's 50th Anniversary—Cocktails and Dinner<br>Reception—State Ballroom<br>Dinner—Grand Ballroom | |

## Tuesday, April 4: "Auxiliary Today"

| | | |
|---|---|---|
| **8:00-4:00** | Registration | *Sixth Floor* |
| **9:00** | Second Session—House of Delegates<br>"County Spotlight"<br>"Health Education with a Flair"—*Dr. Theodore Castele, TV Doctor* | *Adams Room* |
| **11:45** | ISMS Public Affairs Luncheon (Advance Registration Required)<br>Speaker: Susan Bryant, Washington Public Affairs Consultant: Impac-Ampac Regional Workshop immediately following<br>Speaker: George O'Brien, Illinois Congressman, R-17th District | *State Ballroom* |
| **4:00** | "Wine and Cheese Party"—Compliments Chicago Medical Auxiliary | |
| **6:00** | Greek Night (Athens Restaurant) Tour, Dinner and Show | |

## Wednesday, April 5: "Auxiliary Tomorrow"

| | | |
|---|---|---|
| **8:00-noon** | Registration | *Sixth Floor* |
| **8:00** | Breakfast with President-Elect—*Mrs. Earl Klaren* | *Monroe Room* |
| **9:30** | Third Session—House of Delegates<br>Business<br>"Fifty-One to Grow On"—*Mrs. Earl Klaren*<br>Preview of 1978-79 Programs<br>Speaker—Cynthia Niccoli—Rescued "Moonie" Captive<br>County Awards<br>Humanitarian Award—*Mrs. Wilson West* | *Adams Room* |
| **12:30** | Installation Luncheon<br>West Coast Entertainers bring "Sounds of Broadway" | *Monroe Room* |
| **3:00** | Post-Convention Board Meeting | *Adams Room* |

*AMA-ERF Boutique—Sixth Floor*

# Resolutions

### Resolution 78A-1

Introduced by: Loren M. Boon, M.D., for the McLean County Medical Society

Subject: Release from Required Unified Membership with AMA

Referred to: Reference Committee on Amendments to Constitution and Bylaws

---

WHEREAS, The strength of any organization lies in the unanimity with which its members can pursue their common direction and goals; and

WHEREAS, Physicians have permitted themselves to be fragmented and compromised by the promises and blandishments of bureaucratic health planners and other third party entities, which has led to entrapment and subsequent weakening of organized medicine's credibility and influence with our patients; and

WHEREAS, There is increasing dissatisfaction with the edicts and promulgations coming from the "spokesmen" of the AMA which do not accurately reflect the opinions, desires, and will of the grass roots membership; and

WHEREAS, The Illinois State Medical Society is one of the few state medical societies requiring unified membership with the AMA, so that through the years our House of Delegates has always voted to continue this unilateral alliance, but with the often expressed hope that some benefits would accrue to us for such diligent fealty; and none being discernible at this time; therefore be it

RESOLVED, That Line 5 of Chapter II, Section I of the Bylaws be amended by deleting the remainder of the sentence following the words "Annual Meeting", so that it would read as follows:

> Section 1. Dues. Annual dues may be levied by the House of Delegates on each class of membership. The amount of dues shall be recommended by the Board of Trustees and shall be fixed by the House of Delegates at the Annual Meeting ~~and shall include the dues and/or assessments approved by the House of Delegates of the AMA~~. These shall include. . . .

### Resolution 78A-2

Introduced by: David A. Rothstein, M.D.

Subject: Blue Cross/Blue Shield Rider

Referred to: Reference Committee D

---

WHEREAS, Blue Cross/Blue Shield proposes to introduce a new rider for its policies which provides that the Blue Cross/Blue Shield Plan has power of decision as to medical necessity of services and supplies, including hospitalization, over and above the judgment of the treating physician*; and

WHEREAS, Such a provision would transfer an essential element of medical decision from the treating physician to the third party payor and thereby diminish the treating physician's ability to render effective medical treatment according to his best medical judgment (but would not diminish his medical responsibility); and

WHEREAS, Such a provision appears to be an attempt by Blue Cross/Blue Shield to impose a new contractual agreement upon its subscribers in order to circumvent a Court finding that declares such a decision to be contractually "vested solely and exclusively in the judgment and discretion of the treating physician,"**; and

WHEREAS, Such a provision adds vast exclusionary conditions to coverage, reserves to Blue Cross/Blue Shield enormous power to deny benefits, puts patients on notice that they should not rely on their physician's judgment as to medical necessity of their treatment or hospitalization, may deprive patients of the benefits of insurance for which they have paid**, and can incite unwarranted litigation and claims of professional liability (malpractice); and

WHEREAS, Such a provision appears to be an attempt by Blue Cross/Blue Shield to gain contractual authorization to do utilization review and is contrary to the ISMS position to oppose any attempt by Blue Cross/Blue Shield or other third party payors to institute utilization review of hospital patients in the private sector which bypasses local physician review mechanisms; and

WHEREAS, Such a provision, if not effectively opposed, may be looked upon as a model by Government Health Planners; therefore, be it

RESOLVED, That ISMS declare its opposition to any clause or provision in any Hospital/Medical/Health Insurance which transfers medical decision-making power from the treating physician to a third party payor (for procedures which the insurance covers); and be it further

RESOLVED, That ISMS declare that the medical judgment of the treating physician must not be abrogated by Blue Cross/Blue Shield or other third party payors; and be it further

RESOLVED, That ISMS specifically declare its opposition to the proposed Blue Cross/Blue Shield rider which provides that the Blue Cross/Blue Shield Plan has power of decision as to medical necessity of services and supplies, including hospitalization, over and above the judgment of the treating physician; and be it further

RESOLVED, That ISMS advise Blue Cross/Blue Shield of its opposition to this rider and seek to prevent its adoption or implementation or seek its removal; and be it further

RESOLVED, That ISMS register its opposition to this rider with the Illinois Department of Insurance and seek administrative disapproval of the provision, and be it further

RESOLVED, That ISMS communicate this position to the AMA House of Delegates.

*Rider Concerning Exclusion of Services and Supplies not Medically Necessary; Health Care Service Corporation (a Blue Cross and Blue Shield Plan) by S. Martin Hickman, President and Brian Van Vlierbergen, Secretary, attached to original resolution.

**_Van Vactor v. Blue Cross Association:_ 365 N.E. 2d 638.

### Resolution 78A-3

Introduced by: C. J. Jannings, III, M.D., for the Wayne County Medical Society

Subject: Basic Courses in Nutrition

Referred to: Reference Committee C

---

WHEREAS, The curriculum directory of the AAMC for 1977-78 shows that only 10 of the 124 American and Puerto Rican schools listed even mention nutrition as a required course; and

WHEREAS, The length of the required course in 70% of those mentioned is 12-15 hours over a period of four years; and

WHEREAS, A knowledge of nutrition is basic to good patient care in all specialties; and

WHEREAS, It is becoming clear that much morbidity and mortality in this country results from improper nutrition, such as fetal alcohol syndrome, obesity, diabetes, hyperlipidemia and many other conditions; and

WHEREAS, The American people should turn to their personal physician for medical information and guidance in nutritional matters; therefore be it

RESOLVED, That the Illinois State Medical Society petition the American Medical Association to take action to assure that basic courses in nutrition are presented as a required subject in all medical schools in the United States and Puerto Rico.

### Resolution 78A-4

Introduced by: Samuel J. Schimel, M.D.

Subject: Professional Liability Insurance as a Condition for Staff Appointments

Referred to: Reference Committee D

---

WHEREAS, Many hospitals in Illinois do not grant staff privileges unless the doctors show proof that they have obtained professional liability insurance; and

WHEREAS, Certain hospital Boards of Trustees mandate specific amounts of insurance a staff member must carry; and

WHEREAS, Such practices are not justified since every physician should have the right to carry or not to carry insurance or have the amount he deems necessary; therefore be it

RESOLVED, That ISMS oppose any hospital enforcement of regulations which make professional liability insurance a condition for staff appointment and to take steps to change these regulations.

### Resolution 78A-5

Introduced by: David A. Rothstein, M.D.

Subject: Utilization Review by Blue Cross/Blue Shield

Referred to: Reference Committee D

---

WHEREAS, ISMS has declared opposition to any intent or attempt by Blue Cross/Blue Shield or other third party payors to institute utilization review of hospital patients in the private sector which bypasses local physician review mechanisms; and

WHEREAS, Blue Cross/Blue Shield purports to be doing individual case-by-case adjudication of claims and not to be doing utilization review; and

WHEREAS, The Blue Cross/Blue Shield Medical Director has not been able to clearly describe the differences between Blue Cross/Blue Shield's concept of the two processes and has acknowledged that in many cases Blue Cross/Blue Shield's case by case adjudication of claims can be more accurately described as utilization review; therefore, be it

RESOLVED, That ISMS advise Blue Cross/Blue Shield to carefully limit its case-by-case adjudication of claims to those individual cases where it is clearly warranted; and be it further

RESOLVED, That ISMS vigorously oppose any intent or attempt by Blue Cross/Blue Shield or other third party payors to expand the case by case adjudication of claims process to the point of being utilization review or any intent or attempt by Blue Cross/Blue Shield or other third party payors to indirectly institute utilization review under the guise of case-by-case adjudication of claims; and be it further

RESOLVED, That ISMS advise Blue Cross/Blue Shield or any other third party payors to cease indirect utilization review wherever it is already begun, and be it further

RESOLVED, That ISMS communicate this position to the AMA House of Delegates.

# Illinois State Medical Society Student Business Session Annual Meeting

*Saturday, April 1, 1978* *Palmer House*

The Student Business Session of the ISMS has scheduled an educational presentation entitled *LAW, LITIGATION & MEDICINE.* The program will be presented on Saturday, April 1, during the first portion of the 1978 annual business meeting. It is directed toward informing attendings, housestaff and medical students of their legal rights, obligations and liabilities in providing medical services for hospital patients. Category 2 CME credit is available to participants.

The overview will initiate with a brief historical perspective concerning the ancient roots of governmental regulation of medicine and its practitioners. Two knowledgable speakers will then present essential precepts of law and litigation of importance to modern medical professionals. Hospital contract law, informed consent, "malpractice" or negligence, and liability arising from breaches of "agreements" between physician and patient will be discussed. Litigation, the courts, and physician and student as plaintiff, defendant, and witness will be discussed. Emphasis will be placed on the function of judge and jury; their respective roles in evaluating the evidence and arriving at a verdict will be examined. This evidentiary aspect is of particular importance to the attendings, housestaff and students because they are responsible for creating much of the trial evidence. This ordinarily takes the form of business records, *i.e.,* charts and notations which they produce during daily rounds and patient examinations. These records often substantially influence the outcome of a trial and should, accordingly, be of real concern to those providing patient care.

Dan Shirey, J.D.
Joe Ketcherside
*Co-Chairmen*

## *AGENDA*

**1:00-4:00 p.m.** Educational Program: "Law, Litigation and Medicine"
Speakers: Stephen Ell, Ph.D., medical student
Thomas G. Baffes, M.D., J.D., chairman, dept. of surgery, Mt. Sinai Hospital and prof. of surgery, Rush Pres.-St. Luke's Med. Cntr.
Lee Forres, J.D., asst. exec. adm., Chicago Medical Society
Category II CME Credits Awarded

**4:00-5:30** SBS Business Meeting
Reports of Officers
Reports of ISMS Council Members
Discussion of Issues Facing Medical Students
Elections to Office in SBS

*Refreshments will be served during the business session.*

# *Physicians and Auxilians of the Illinois State Medical Society are cordially invited to a complimentary Public Affairs Luncheon*

11:45 a.m., Tuesday, April 4, 1978

Palmer House Hotel Chicago

**Space limitations require advance registration**

---

☐ Yes, I will attend the Public Affairs Luncheon.

Name _____ Address _____

Phone _____

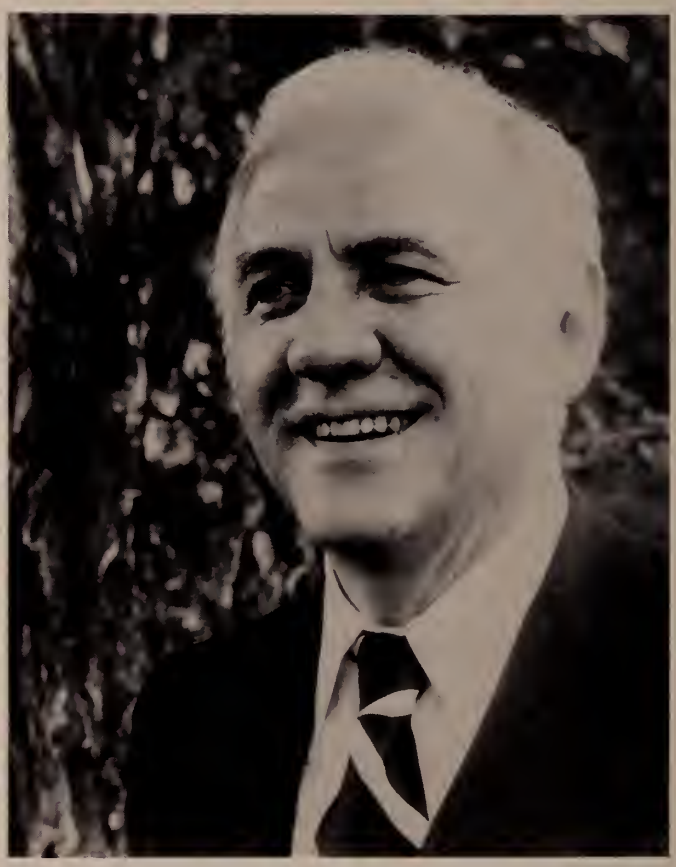
Please return to: Public Affairs Committee
Illinois State Medical Society
Suite 3510
55 East Monroe Street
Chicago, Illinois 60603

Reservations confirmed on a first come/first served basis.

# *IMPAC-AMPAC Regional Workshop*

# *Tuesday, April 4, 1978*

# *featuring*



**Honorable George O'Brien**
**Member of Congress**
**Illinois 17th District**

## *(Immediately following ISMS Public Affairs Luncheon)*

# Schedule of Associated Meetings

## ISMS Workshop on Alcoholism Treatment

**Monday, April 3, 1978** **8:30 a.m.-12:30 p.m.**

**8:30** Educational seminar on diagnosis, confrontation and treatment of alcoholism. Discussion of etiologic clinical aspects and rehabilitative techniques pertinent to every practicing physician.

**10:30** "Prevention of the Fetal Alcoholism Syndrome." Henry Rosett, M.D., associate professor of psychiatry, Boston University School of Medicine Maternal Health and Child Development Program. Doctor Rosett's presentation is open to physicians and interested paraprofessionals.

Program chairman: James W. West, M.D.

Sponsored by the ISMS Committee on Alcoholism and Drug Dependence with the support of the Illinois Department of Mental Health and Developmental Disabilities Division of Alcoholism and the University of Illinois School of Public Health. Category 2 CME credit is available to participants.

---

## Second Annual Meeting of CME Accreditation Examiners

**Monday, April 3, 1978** **10:30-4:30 p.m.**

Special workshop providing:
—An opportunity for examiners to exchange ideas with colleagues
—Orientation on examiner responsibilities
—Information on new developments in CME, at both state and national levels.

This annual gathering is another unique feature of CME accreditation in Illinois

---

## Illinois Society of Pathologists

**Tuesday, April 4, 1978** **9:00 a.m.**

Clinical Symposium: "Pathology of Tumors of the Head and Neck"

Presented by Paul Szanto, M.D., under the auspices of the Illinois Registry of Anatomic Pathology

---

## Seminar: Establishing Yourself in Private Practice

**Tuesday, April 4, 1978** **9:00 a.m.**

An educational symposium conducted by Robert J. Kramer, M.D. and Ken P. Jesunas, M.D.

For registration information, please contact ISMS headquarters.

NONPARTISAN

# IMPAC

**ILLINOIS MEDICAL POLITICAL ACTION COMMITTEE**
55 East Monroe Street
Chicago, Illinois 60603
312/782-1963

February 8, 1978

## NOTIFICATION OF IMPAC ANNUAL MEETING

The 1978 annual meeting of the Illinois Medical Political Action Committee will be held on Monday, April 3, 1978, immediately following the adjournment of the Second Session of the ISMS House of Delegates:

3:30 P.M. (approximate time)
Red Lacquer Room
Palmer House
Chicago, Illinois

All members of IMPAC are invited and encouraged to attend.

The 1978 IMPAC Nominating Committee has met and nominated the following individuals for membership on the IMPAC Council:

### Terms Expiring 1981

| | |
|---|---|
| Louis Dondanville, M.D. | Moline |
| Edwin L. Falloon, M.D. | Evergreen Park |
| Morris T. Friedell | Chicago |
| Don Hinderliter, M.D. | Rochelle |
| John W. Ovitz, Jr., M.D. | Sycamore |
| Albert W. Ray, Jr., M.D. | Joliet |
| P. John Seward, M.D. | Rockford |
| Herbert Sohn, M.D. | Chicago |
| A. E. Steer, M.D. | Springfield |
| Philip G. Thomsen, M.D. | Dolton |

### Terms Expiring 1979

| | |
|---|---|
| Clifton L. Reeder, M.D. (to fill the unexpired term of Elliott Partridge, M.D.) | Park Ridge |

Pam Taylor
Chairman

Contributions are not limited to the suggested amount. Neither the Illinois State Medical Society nor the AMA will favor or disadvantage anyone based upon the amounts of or failure to make pac contributions. Copies of IMPAC & AMPAC reports are filed with the Federal Election Commission, Washington, D.C. Contributions are subject to the limitations of FEC regulations, Sections 110.1, 110.2 & 110.5. (Federal regulations require this notice.) IMPAC reports are also filed with the State Board of Elections, and are or will be available for purchase from the State Board of Elections, 1020 S. Spring St., Springfield, Illinois, 62704

# IF INSURANCE IS YOUR PROBLEM. . . .

## THE EXCHANGE HAS THE ANSWER

## Come By And See Us At The ISMS Annual Meeting



Illinois State Medical
**Inter-Insurance Exchange**
55 East Monroe Street, Chicago, Illinois 60603

# CONVENTION '78

## The 138th Annual Meeting
*of the*
## Illinois State Medical Society
*will be held at the*
## Palmer House, State and Monroe
## Chicago, Illinois
## April 2-5, 1978

- **ISMS House of Delegates**
- **Specialty Society Scientific Programs**
- **Gala President's Party & 50th Anniversary ISMS Auxiliary**
- **Annual IMPAC Meeting**
- **Public Affairs Luncheon**

Further information about Convention may be obtained by contacting the Illinois State Medical Society, 55 E. Monroe, Suite 3510, Chicago, Illinois 60603. Phone: (312) 782-1654.

## PLAN NOW TO ATTEND . . . . CONVENTION '78
### April 2-5, 1978, Palmer House, Chicago

For reservations, check accommodations desired and mail to:

Palmer House - Reservation Department
State and Monroe Streets
Chicago, Illinois 60690

**Name** _____

**Company Name** ILLINOIS STATE MEDICAL SOCIETY & AUXILIARY ANNUAL MEETING

**Address** _____

**City** _____ **State** _____ **Zip** _____

**Arrival** _____ **Hour** _____ **am pm** **Departure Date** _____

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| **Single** | ___$40 | ___$44 | ___$47 | ___$52 | ___$57 | | **Palmer House Towers** | | | | |
| **Double** | ___$52 | ___$56 | ___$59 | ___$64 | ___$69 | **Single** | ___$47 | ___$52 | ___$57 | ___$62 |
| **Twin** | ___$52 | ___$56 | ___$59 | ___$64 | ___$69 | **Double** | ___$59 | ___$64 | ___$69 | ___$74 |
| **Parlor and 1 Bedroom Suite** | | | | ___ $120 & up | | **Parlor and 1 Bedroom Suite** | | | ___$145 & up | |
| **Parlor and 2 Bedroom Suite** | | | | ___ $195 & up | | **Parlor and 2 Bedroom Suite** | | | ___$249 & up | |

For better choice of accommodations, early reservations are suggested. If rate requested is not available, the next available rate will be confirmed. Rooms will be held until 6:00 p.m. on stated date of arrival, unless a later time is confirmed.

All room rates are subject to additional 6.1% charge to cover Illinois hotel operators' occupation tax and Chicago hotel operator's tax, as well as a 2% Chicago accommodations tax imposed by the city of Chicago.

ISMS CONVENTION DATES 4/2-4/5/78

# *Abstracts of Board Actions*

*(Continued from page 179)*

## ICCME

The Board adopted a report of the ISMS-ICCME Liaison Committee which agreed in principle that ISMS should delegate to ICCME full responsibility for administering the program of CME accreditation surveys and review. Currently, ICCME conducts surveys and reviews, reporting its findings to an ISMS-staffed accreditation committee. The new arrangement is aimed at eliminating dual administrative roles in the operation of the accreditation program.

Under the new arrangement, ICCME would: (1) Operate under rules approved by the ISMS Board; (2) Report individual accreditation actions to the ISMS Board for approval; and (3) Deal directly with the national Liaison Committee on CME (LCCME) in matters affecting accreditation. Final arrangements are contingent upon rules being formulated by LCCME—which recently has assumed responsibility for the national accreditation program.

## Computer Consultant

Ernst & Ernst, Inc., Chicago, was retained to assist ISMS in instituting more formal control over data processing activities and in formulating data processing plans designed to meet short and long range goals. The action followed completion of an analysis of the ISMS computer operation by Arthur Young & Co., Chicago, which commented favorably on the overall ISMS computer operation and recommended retaining an outside firm to assist with the planning.

## Designated Products

The Board endorsed use of the following Schedule II "designated product" categories requiring a triplicate prescription form: narcotics, opiates, amphetamines, methamphetamine and methaqualone. The Illinois Dangerous Drugs Commission tentatively has agreed with the listing, apparently ending a major dispute with the Society. In 1976, ISMS filed suit against DDC over inclusion of amo-, pento-, and secobarbital as "designated products." The Society voluntarily dismissed the suit when DDC agreed to meet and attempt to resolve the issue.

## Laetrile

ISMS will vigorously oppose—possibly through legal action—any legislative efforts to exempt specific drugs from provisions of the Illinois Food, Drug and Cosmetic Act. The action was prompted by the recent exclusion of amygdalin (laetrile) from the Act's jurisdiction. In other action concerning laetrile, the Board:

- Endorsed IDPH efforts to maintain drug laws and guarantee purity of product for Illinois citizens.
- Endorsed a "model" affidavit that physicians may use in attesting—as required by law—that the patient receiving the substance has been examined within the past three months and diagnosed as having terminal cancer. Physicians will be urged to maintain copies of the affidavit—developed by ISMS legal counsel—with the patient's file and chart, and forward a copy to IDPH.
- Cautioned that amygdalin (laetrile) should be administered to minors only upon court order.

## Definition of Psychologist

ISMS will voice objection to the Illinois Department of Insurance over use of a definition broadly-defining psychologists eligible for direct reimbursement for mental health services under health insurance. ISMS will state that Part B of the definition—in regulations implementing HB 1080—is too general, thus allowing poorly-trained persons to provide "medical" care.

## Legislation

ISMS will seek legislation in the upcoming General Assembly session to:

- Repeal all portions of recently-enacted HB 1080 which provide for compulsory insurance coverage of non-medical independent practitioners providing treatment for mental illness.
- Classify as aggravated battery the assault of hospital emergency room personnel.
- Set a one-time issuance of state controlled substances number at the time of licensure. Continuation of the number would be tied to the physician's regular medical license renewal and would be granted without additional fees.

In other action concerning legislation, the Board voted to: (1) Oppose any legislation that would remove a provision from the current drug substitution law requiring IDPH to monitor cost savings to consumers; (2) Seek introduction of a joint House-Senate resolution commending the Illinois Cancer Council for its activities, specifically the new statewide comprehensive cancer patient data system; (3) Oppose HB 2506 which would create a Limited License Review Board to make individual recommendations for continuation of the limited licenses of those "permit" doctors now employed by the state; and (4) Oppose SB 1040 which seeks to amend the Medical Corporation Act to authorize the inclusion of optometrists, podiatrists and dentists in medical corporations.

## Immunity of Hospital Records

ISMS will monitor two pending court suits—involving confidentiality of hospital staff committee peer review records—with a view toward filing a friend-of-the-court brief in one of the cases to protect immunity provisions of Illinois statutes. In addition to monitoring the cases, ISMS will seek a legislative amendment to strengthen the statutes.

## Assistance to Hospital Medical Staffs

ISMS will offer to provide hospital medical staffs with limited assistance—including legal advice—in matters of governance and privileges upon the request of a majority of medical staff members who also are ISMS members. Continued assistance would be provided at the expense of the medical staff in situations which require extended expense or staff time. The action was prompted by numerous medical staff requests for assistance in developing bylaws.

## National Guidelines for Health Planning

HEW and AMA will be informed of the Society's objections to several facets of the revised National Guidelines for Health Planning that were issued late last month. Component and specialty societies also will be urged to inform HEW of their objections.

## Administrative Services To Specialty Societies

ISMS will seek to expand its administrative services to specialty societies and coordinate these services with the Council on Affiliate Societies. ISMS currently provides such services on a cost reimbursement basis for the Ill. Assn. of Ophthalmology, Ill. Society of Internal Medicine, Ill. Psychiatric Society and the Ill. Chapter-American Academy of Pediatrics.

## Hospital Cost Effectiveness Committees

The Board ratified distribution of a memorandum—by the Task Force on Cost Effectiveness—to all Illinois hospital administrators and chiefs of medical staffs urging formation of joint administration-medical staff committees on cost effectiveness. The committees—reporting through the medical staff structure—were urged to consider implementing the following measures:

- Periodically review standing orders for routine diagnostic testing to determine their necessity in all cases.
- Make available for physician inspection samples of hospital patient bills for typical cases . . . or, at random, provide a copy of a patient's bill for the attending physician's review.
- Include programs in hospital CME curricula on the cost ramifications of physicians' orders.
- Disseminate information on proven cost containment measures to members of the hospital and medical staffs.

The hospital committees also were urged to consider implementing patient education programs.

The Task Force is expected to be called upon to implement at the state level the voluntary hospital cost containment recommendations formulated by a national steering committee composed of AMA, American Hospital Association and the Federation of American Hospitals.

## Planned Parenthood Service

The following position was adopted concerning contraceptives provided by local planned parenthood organizations:

> Oral contraceptives should be dispensed only under the specific orders of a physician who has examined the particular patient.

## IDPA Drug Manual

The following drugs were approved for inclusion in the IDPA Drug Manual: Tylox, Pneumovax, Imodium, Verstran, New Theophyl Chewable tablets, New Theophyl-SR, Salutensin tablets, Naldecon tablets, Naldecon syrup, Naldecon Pediatric drops, Naldecon Pediatric syrup, Optimine, Debrisan, Somophylline capsules (automatic), Lioresal and Disalcid.

## Ill. Dept. of Vocational Rehabilitation

ISMS will work with the Illinois Department of Vocational Rehabilitation in developing a Medical Advisory Committee to deal with Department policy and programs. Once provisions are made for the establishment of such an advisory committee, ISMS will nominate, if requested, physicians for appointment.

## Voluntary Medical, Surgical Program

An ad hoc committee was created to study the feasibility of developing and implementing a statewide voluntary medical and surgical care program—such as an individual practice association. Named to the committee that will develop several concepts were: Drs. A. Beaumont Johnson, Elgin; Glen Tomlinson, Lincoln; Robert Hartman, Jacksonville; Joseph Bordenave, Geneva; and David Fox, Joseph Sherrick and Fredric Lake of Chicago. Last November, the House of Delegates directed the Board to explore the possibility of establishing the medical-surgical program.

## Medicare Misconceptions

A sample copy of the updated pamphlet, entitled "Medicare Misconceptions," will be mailed to all ISMS members. The pamphlet will be offered at cost—$5 for 250 copies—for distribution to patients by physicians, hospitals, nursing homes, insurance companies and consumer groups.

## Appointments

Dr. Jere Freidheim, Chicago, was appointed to the ISMS Board of Trustees replacing Dr. Herman Wing, Chicago, who resigned as Third District Trustee.

Appointed to the newly-created Illinois Medical Journal Editorial Board—functioning under the Publications Committee—responsible for IMJ content and editorial philosophy were: Drs. J. William Roddick, Jr., chairman, Springfield; Daniel Cunningham, Maywood; Carl Neuhoff, Peoria; Donald Van Fossan, Springfield; Eli Borkon, Carbondale; Raymond Dieter, Glen Ellyn; James Ekeberg, Palatine; Constantine Soter, Arlington Heights; and Ediz Ezdinli, Kenilworth.

Named to a special study Committee for Designated Products to analyze—and advise the Dangerous Drugs Commission on—the propriety of placing certain drugs in the "designated product" category requiring triplicate prescriptions were: Drs. Edward Senay, Chicago; Albert Ray, Jr., Joliet; Patrick Staunton, Oak Park; Richard Suhs, Springfield; and Richard Albers, Lombard.

Appointed to fill vacancies on ISMS councils and committees were:

- Dr. Charles Eddingfield, Carthage—chairman, Committee on Physician's Assistants
- Dr. Philip Boren, Carmi—Insurance Committee
- Dr. Harold Lasky, Chicago—Ethical Relations Committee
- Dr. Allan Campbell, Peoria—Accreditation Committee
- Dr. Naomi Morris, Highland Park—Committee on Physician's Assistants

Named to the recently-created Committee on Physician Recruitment of the Council on Education and Manpower were: Drs. John Devitt, Springfield, chairman; Bernard Baalman, Hardin; David Bristow, Effingham; J. M. Ingalls, Paris; C. J. Jannings III, Fairfield; Julius Kowalski, Princeton; Albert Maurer, Hopedale; and Donald Rames, Vandalia. Two additional members will be named by both the Resident Physicians Section and Student Business Session. Dr. Devitt also was appointed to the Council on Education and Manpower.

Dr. Edward Ryan, Palos Heights, was named the ISMS representative to the March of Dimes' Advisory Committee on Perinatal Health Services. The Committee will determine which perinatal services should be supported by the March of Dimes.

## Family Planning Clinic

ISMS will protest the operation of a federally-funded family planning clinic in Centralia, noting that the clinic is not cost effective. Clinic funding for the first half of 1978 is $60,000, and the clinic expects to see approximately 120 patients—translating into a cost of $500 per patient. Letters of protest will be sent to HEW, Illinois Congressional delegation, General Assembly, Governor Thompson and IDPH. ISMS also will assist the Marion County Medical Society in publicizing the clinic's lack of cost effectiveness.

# Guest Editorial

## *A LONG LOOK AHEAD*

By Richard L. Lesher, President, Chamber of Commerce of the United States

What influences are likely to shape our economy and society from five years ahead on out to the turn of the century? What are the really enduring trends, the things we can reasonably count on?

1) Slower growth. In the past, our economy has expanded at about 4.5% a year. We probably won't be able to keep that up much longer. Growth may drop down to a rate as low as 2.5%.

The implications of a slower rate of economic growth are more serious than the few percentage points difference in the figures indicate. When the pie gets larger each year, it is possible to give a bigger slice to previously deprived groups without having to give a smaller piece to anyone else. Thus, everyone is reasonably happy. But if the pie doesn't grow much, then giving more to group "A" means taking some from group "B." That is a formula for rising social tension and disruption.

2) An aging population. Because of the declining birth rate, the average age of the population is increasing. Five years ago it was 27. Now it is up to 29. It will go up to 37 in the decade ahead. Since older populations tend to be more conservative, this trend may offset some of the disruptive pressures of a lower growth rate.

3) International trade will become more important to us. The economies of the world are growing increasingly interdependent and nothing short of a major disaster is going to change that.

4) Inflation will continue. Inflation is useful to a government. It permits the government to increase its revenues automatically. Thus, the politicians have more money to hand out (for which they get credit at the polls) without suffering the blame for raising taxes.

5) The government will grow larger and more powerful.

I don't want this last prediction to come true. But it will, unless a majority of us realize that our need for protection *from* the government is becoming greater than our need for protection *by* the government.


**COOK COUNTY**
**Graduate School of Medicine**

CONTINUING EDUCATION COURSES
STARTING DATES—1978

NEUROLOGY, PART I, BASIC, 5 and a half days, March 6
BASIC INTERNAL MEDICINE, 5 days, March 6
SPECIALTY REVIEW SURGERY, PART II, March 6
BASIC EKG, 5 days, March 27
EKG FOR ANESTHESIOLOGISTS, 5 days, March 27
BASIC PSYCHIATRY, 5 days, April 3
SPECIALTY REVIEW UROLOGY, 5 days, April 10
BASIC SEMINAR & WORKSHOP IN ECHOCARDIOGRAPHY, April 19
STATE & NAT'L. BD. REV. BASIC, April 30, CLINICAL, May 8
SPECIALTY REVIEW PULMONARY DISEASE, April 24
ESSENTIALS OF DERMATOLOGY, 5 days, May 1
ADVANCES IN SURGERY, 5 days, May 8
SPECIALTY REVIEW NEPHROLOGY, May 8
SPECIALTY REVIEW RHEUMATOLOGY, May 8
SPECIALTY REVIEW ANESTHESIOLOGY, May 14
SPECIALTY REVIEW OBSTETRICS & GYNECOLOGY, May 15
ADVANCES IN FAMILY PRACTICE, 5 days, May 15

*Information concerning numerous other continuation courses available upon request.*

**Address:**
**REGISTRAR, 707 South Wood Street,**
**Chicago, Ill. 60612**



**Physicians,**

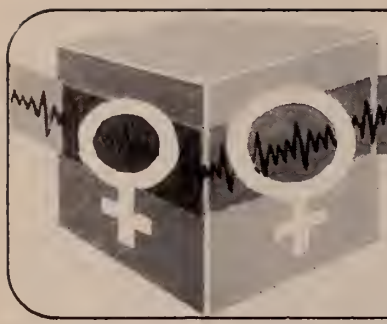
consider a practice in South Carolina

* low malpractice insurance rates, * the opportunity to join a group or partner or establish a new practice in a rural or urban area, * continuing medical education through a system of Area Health Education Centers, as well as two medical schools, * lower taxes, * lower cost of living, * access to both mountains and beaches, and * a mild climate

For information about specific practice opportunities in South Carolina, contact:

rural health delivery project

Post Office Box 11188
Columbia, South Carolina 29211
(803) 779-7264



# *pulse...* of the ISMS auxiliary

Mrs. Eugene Vickery, Editor



## *KEY LINES:*

By Betty Szewczyk, President, ISMSA

*50th Annual Meeting of the ISMSA will be held April 2-5 at the Palmer House, Chicago. Come and join the celebration of "Auxiliary Yesterday, Today and Tomorrow"*

Attendance reached a new high at winter board meeting at the Drake Hotel in Chicago on January 24 and thirty-five stout-hearted board members were rewarded with pleasant weather in the windy city. The call to order came at 9:35 while many papers and chairs were still shuffling. Order came quickly and here are some of the interesting excerpts from reports. . . .

MRS. H. FRANK HOLMAN, Convention Chairman, presented a tentative schedule which has developed into a full-fledged permanent schedule that includes three days of action-packed convention for our fiftieth annual meeting. Special features will be a Board Dinner and Reception honoring Members-at-Large, both scheduled for Sunday, April 2. Monday and Tuesday evenings offer outstanding events—ISMS President George Wilkins has invited the auxiliary to join him at the President's Dinner on Monday night, April 3, in celebration of the Auxiliary's Fifty Years. Special souvenir glasses will be featured in a champagne toast. A "Greek Night" is offered for Tuesday, April 4, including twilight tour, dinner and show. MRS. JACK CLEMIS has extended an invitation from the Chicago Medical Auxiliary to a "Wine and Cheese Tasting Party" on Tuesday at 4:00 p.m. Scheduled speakers will be: Mrs. Chester Young, AMAA President; Marilyn Van Derbur, Miss America 1958 and head of Motivational Institute, Denver; and Dr. Theodore Castele, Cleveland's TV Doctor. Wednesday, April 5, will be "Auxiliary Tomorrow." President-Elect MRS. EARL KLAREN will present a preview of 1978-79 programs. This is a new concept for annual meeting and will allow county people to take home a good working plan for the coming year.

First Vice President MRS. WILLIAM HODGES presented a report of the Special Committee to Study Honorary 50 Year Memberships which stated that honorary membership was not feasible at this time. Several alternatives were recommended. Individual counties could make qualifying members honorary and pay their state and national dues or ISMSA might award a Certifiicate of Recognition to be presented or mailed to qualified members at the time of annual convention. A third alternative suggested that the program booklet for annual convention have a special page dedicated to the counties organized fifty years, including the names of qualified members.

Benevolence Chairman MRS. ALFRED FABER reported that final totals will not be in until June 30, but hoped that our contributions will top those of last year. She also reported that at present there are 19 recipients, including one physician and 18 widows of physicians. The largest amount received is $200 monthly. The ISMS Benevolence Fund Committee, with auxiliary representation, met on February 8 to discuss possible future changes. Auxiliary is working on a new memorial envelope that will make giving easier and more convenient.

Community Health Chairman MRS. HAROLD KEEGAN, represented the auxiliary at a day long workshop study on the Impaired Physician. She recommended that the auxiliary urge ISMS and, in fact, offer to help develop a substantial program to solve the problem.

A quote from MRS. BYRON WEISBAUM, Legislative Chairman: "It is difficult to stimulate interest and motivation . . . rather like legislating love for your fellow man, and any suggestions to accomplish this feat will be gratefully accepted. Until each county president and legislative chairman becomes more demanding with its membership, the efforts will still fall well below its intended mark."

A bonus for the board members was a talk by MRS. ALAN TAYLOR, IMPAC Chairman, an auxiliary member who leads by her example. Pam is the first non-physician chief executive officer in the 16-year history of IMPAC. IMPAC is a voluntary membership organization designed to promote political education and activity by physicians.

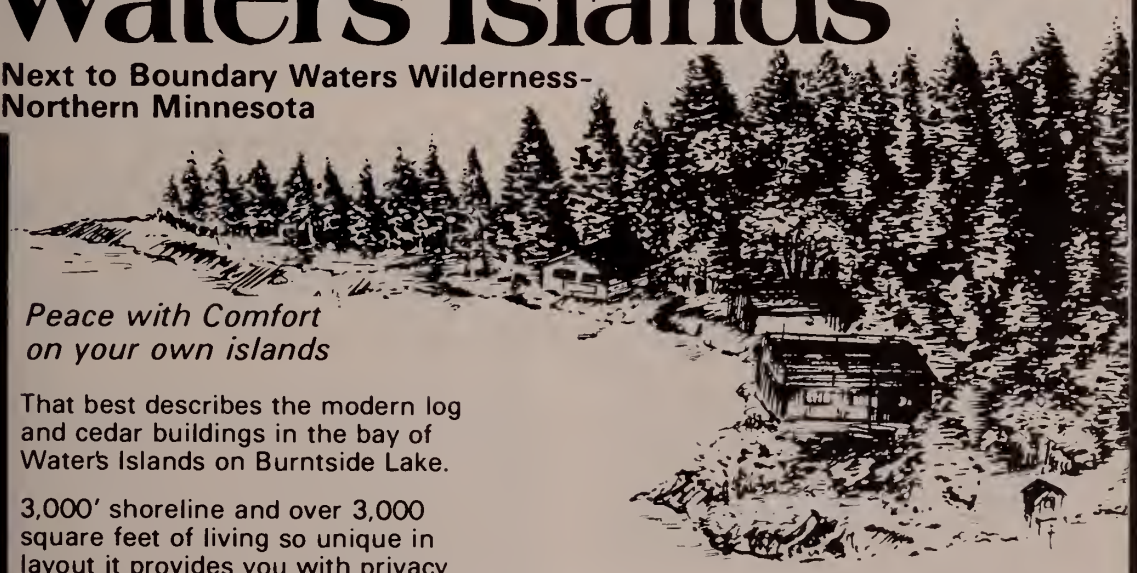
MRS. WILLIAM WALKER, AMAA Membership Vice-President, addressed the group, and the district councilors in particular, about the importance of the councilors as liaisons between counties and state. Her membership enthusiasm was felt throughout the room and added a badly needed spark in many county membership plans.

The Nominating Committee report was given by Chairman MRS. JOHN OVITZ and the following slate was unanimously approved:

| | |
|---|---|
| President | Mrs. Earl Klaren |
| President-Elect | Mrs. R. Samuel Hoover |
| First Vice President | Mrs. Harlan Failor |
| Second Vice President | Mrs. Don Hinderliter |
| Third Vice President | Mrs. Harold Keegan |
| Recording Secretary | Mrs. Julian Buser |
| Treasurer | Mrs. Robert Webb |
| Director | Mrs. Edward Szewczyk |
| Director | Mrs. William Hodges |
| Director | Mrs. Jaime Gomez |


# Water's Islands

**Next to Boundary Waters Wilderness-Northern Minnesota**



*Peace with Comfort on your own islands*

That best describes the modern log and cedar buildings in the bay of Water's Islands on Burntside Lake.

3,000' shoreline and over 3,000 square feet of living so unique in layout it provides you with privacy while you share this wilderness experience with your friends.

**OFFERED AT $242,000**

*For a brochure and more information, write*

**WESTERN REALTY**

Stephen Spencer

2129 West Superior ● Duluth, MN 55806

# CLASSIFIED ADVERTISING

## POSITIONS & PRACTICE OPPORTUNITIES

**OB-GYN, ENT, PEDIATRICS, SPECIALISTS** needed by 16-man multi-specialty clinic in university community of 50,000 in western Wisconsin; excellent retirement and fringe benefits; fine recreational opportunities; salary negotiable. Send curriculum vitae and references to: John R. Ujda, M.D., La Crosse Clinic, 212 South 11th Street, La Crosse, Wisconsin 54601.

**FULL TIME PHYSICIAN** for Industrial Clinic in Skokie. Surgical experience needed. Salary negotiable. Must have Illinois license. Call (312) 674-4800, Mrs. McCubbin.

**OPPORTUNITIES FOR PHYSICIANS IN INDIANA**—There are several excellent openings among the Indiana State Hospitals at various locations throughout the state for psychiatrists and physicians of other specialties, at most experience levels. A newly-revised salary schedule offers a very competitive income plus a generous package of fringe benefits. An adjunct practice is possible beyond the regular working hours and on-call responsibilities. Please reply with a copy of the c.v. to: Farabee & Associates, Inc., P.O. Box 472, Murray, KY 42071 or call (collect) (502) 753-9772. Farabee is retained by the Indiana Department of Mental Health.

**EMERGENCY PHYSICIAN, McHENRY:** Full-time career-oriented emergency physician to begin July 1 in 17,000 visit/year emergency department of 140-bed mobile-intensive-care resource hospital and trauma center 50 miles northwest of Chicago. Small town (pop. 8,000). Ski and water sports area. Good back-up from 20-man multi-specialty clinic in adjacent building and from independent specialists in community. Salary and fringes competitive with Chicago area. Send curriculum vitae to: John L. 8owman, M.D., Director, Emergency Services, McHenry Hospital, 3516 W. Waukegan Road, McHenry, IL 60050.

**PSYCHIATRIST:** 8oard eligible or board certified with license to practice in Illinois or abiity to obtain same. Full time position with well established community mental health center located in a very attractive area of northwestern Illinois ninety minutes from metropolitan Chicago. Income and fringe benefit package highly competitive and negotiable. Excellent opportunity for the right person who is committed to inter-disciplinary team approach, community mental health models of intervention, and a lifestyle that combines the best of rural living with access to urban stimulation. Psychiatric services would include both outpatient and inpatient components. For additional information, contact Albert E. Graff, Executive Director, Sinnissippi Mental Health Center, Dixon-Sterling Freeway, Dixon, Illinois 61021. Phone collect (815) 284-6611.

**MEDICAL DIRECTOR:** Excellent opportunity for administratively oriented physician. Work in program design at the central office and practice at the new diagnostic and evaluation center. Supervise approximately 50 health care personnel. Excellent state benefits, salary to start in the mid 40's. Send resume to: Dept. of Correctional Services, P.O. Box 94661, Lincoln, Nebraska 68509.
An Equal Opportunity Employer

**EMERGENCY PHYSICIANS—FULL OR PART TIME:** needed for Danville, Peoria, Streator, Princeton, Monmouth, and Moline, Illinois; compensation to $75,000. Prefer physicians with prior E.R. experience. CPR training is required. Call 800-356-9034 or send C.V. to Central States Emergency Physicians, P.O. 8ox 659, Moline, Illinois, 61265.

**SOUTHERN MEDICAL CENTER** will be seeking a Family Practice physician and a General Internal Medicine physician with Illinois licenses or reciprocity status. The private practice is in a newly remodeled building for physicians and allied health services. Excellent salary guarantee with participation in excess, fringe benefits. Office expenses and malpractice paid. Hospital will pay recruiting expenses for physician and family. Call 618/734-2400 or write Harvey H. Pettry, Administrator, Southern Medical Center, 2020 Cedar Street, Cairo, IL 62914.

**IMMEDIATE POSITION IN EMERGENCY MEDICINE** available with a fee for service corporation serving a community hospital. Salary competitive. Multiple fringe benefits. Well equipped emergency room with excellent back up in all specialties. Notify: Rockford Acute Primary Care Association, 2500 North Rockton Avenue, Rockford, Illinois 61103.

**BOARD ELIGIBLE PSYCHIATRIST** with experience and/or training evaluating children, to join three psychiatrists for full time position in comprehensive community mental health center. Outpatient duties only. No calls. Opportunities to supervise psychiatric residents, participate in staff, and program development. Salary negotiable plus fringe benefits. Apply: Phoenix South Community Mental Health Center, William Bonfield, M.D., Medical Director, 1424 S. 7th Ave., Phoenix, AZ 85007. (602) 257-9339. An Equal Opportunity Employer, male/female.

**ENJOY THE SECURITY** of group practice with the freedom of independent practice: If you are a Board Certified or 8oard Eligible internist we have an interesting opportunity for you. Two or more internists are needed immediately to form an independent practice in a very desirable Northern Wisconsin community of 65,000. Active practice assured. All major specialists available for consultation. Business advice, technical and legal, will be provided. Outstanding personal benefit programs available. Income potential great. Generous starting income guaranteed. New 35 million dollar hospital to open in 12 months. For further information call (715) 845-2942, or write P.O. Box 963, Wausau, Wisconsin 54401.

## FOR SALE, LEASE OR RENT

**MEDICAL OFFICE** for rent, Moline, Illinois, downtown location. Present occupant retiring O8-GYN. 725 feet, reception room, business area, private office, three examining rooms, laboratory, storage and rest room. 8asement 375 feet. Rest room, laboratory and drug room. Contact Warren R. Streed, D.D.S., 719 16th Street, Moline, Ill. 61265.

**MEDICAL CLINIC**—For rent, lease, or sale. Immediately available, retiring, take over practice, fully equipped modern brick building; well over $100,000 gross; 5 hospitals in area; full community cooperation; suitable for two; 25 miles south of State Capitol. For further information, contact Ted Lay Agency, Box 34, Girard, Illinois 62640. (217) 627-2515 or 627-2835.

**MODERN MEDICAL SUITE,** Homewood area: 800 sq. ft. available immediately. Reception plus 3 to 4 rooms, private bath. Panelled, carpet, air condition, all utilities paid and off-street parking. Convenient to all transportation and south suburban hospitals. Phone Mr. Olsen weekdays: 565-0025; Evenings: 798-8234.

**OFFICE TO SUBLET PART TIME:** professional building. Common waiting room with receptionist suitable for internist, psychiatrist, surgeon. To arrange days and hours call Monday, Tuesday, Thursday: 2-5. (312) 262-0399.

**SUBLEASE:** Part time-ophthalmologist's office. Completely furnished and equipped. (Garland 8ldg.) Phone (312) 236-6368.

**MEDICAL OFFICE SUITE FOR RENT,** Chicago Lincoln-8elmont 8ldg. 715 square feet, available July 1, 1978 in full service with elevator. Active professional building. Call Gary Solomon, (312) 334-5400.

**FOUR ROOM MODERN SUITE** and waiting room. Medical Center, 10444 South Kedzie Avenue, Chicago, Ill. 60655, (312) 239-3000.

**MEDICAL CENTER FOR RENT.** Complete and ready to open. 4300 sq. ft. at 2301 E. 95th Street, Chicago. Large waiting rm., 18 exam rms., x-ray rm., central a/c & heat. Call Gary Solomon, (312) 334-5400.

## SITUATIONS WANTED

**CONSIDERING STAFF ADDITIONS?** Medical Assistants available throughout the state. Robert Morris College has a Medical Assisting Program accredited by the Council on Medical Education of the American Medical Association in collaboration with the American Association of Medical Assistants. Our Medical Assistants are proficient in administrative, clinical, and laboratory areas. Graduates are prescreened prior to application. No fee charged to Employer or Applicant. Call: Toll Free 800-252-9151 or (217) 357-2121; Robert Morris College Placement Center, College Avenue, Carthage, IL 62321.

**PHYSICIAN'S ASSISTANT,** BA, MA, 31, graduate of accredited program, Board eligible, work experience in group practice in major medical center. Relocating. Desires position in Chicago or Northern Illinois. Contact M. J. Van Hook, 1925 Keeney Street, Evanston, Illinois 60202.

**EXPERIENCED ER PHYSICIAN** wants to join emergency room hospital group in permanent ER position. Please write 8ox 910, c/o IMJ, 55 E. Monroe, Suite 3510, Chicago, 60603.

**RADIOLOGIST** seeks permanent part-time position, 4 hrs/day, fluroscopy and/or film reading. Chicago metropolitan area. Please write 8ox 911, c/o IMJ, 55 E. Monroe, Suite 3510, Chicago, IL 60603.

**UNIVERSITY TRAINED, LICENSED,** board eligible pediatrician seeks opportunities in DuPage, Will or Kane County in the West Suburban Chicago area. Has worked in general hospital and children's hospital pediatrics, Emergency Room experienced. Available July, 1978. Reply to IMJ, Box 914 c/o IMJ, 55 E. Monroe, Suite 3510, Chicago, 60603.

**FAMILY PHYSICIAN,** board eligible, seeks to purchase a practice or associate with another family physician or group practice in Chicago or nearby suburb. Reply Box 915, c/o IMJ, 55 E. Monroe, Suite 3510, Chicago, 60603.

## MISCELLANEOUS

**WANTED TO PURCHASE:** Old EKG machine, workable, inexpensive. Phone (312) 332-4424.

## HOBBIES

**PERSONALLY** reconditioned pinball machines for one, two and four players. Ideal for home gameroom. Large selection available. Daniel Hoffman, M.D., (309) 283-2027.

## GUARANTY FUND CERTIFICATE

**ILLINOIS STATE MEDICAL INTER-INSURANCE EXCHANGE GUARANTY FUND CERTIFICATE.** For sale due to retirement. Principal amount $724. Asking price $500. Contact Paul R. Linden, M.D., 719-16th Street, Moline or 309-764-6705.

**GUARANTY FUND CERTIFICATE.** ISMIE Exchange #7761. Orig. cost $960.00, Class II 100-300,000 for sale. Please call: (312) 654-8447.

**FOR SALE:** Leaving Illinois for practice elsewhere. Will sell ISMIE Professional Ins. Guaranty Fund Certificate for $5500, a savings of $500.00 Please reply to Box 913, c/o IMJ, 55 E. Monroe, Suite 3510, Chicago, 60603.

**GUARANTY FUND CERTIFICATE** for sale: Class 5, Territory 11 for $1,000,000/1,000,000 coverage, purchase price $6024. For information, call Mr. Murr (815) 963-9674 or send inquiries to Box 916, c/o IMJ, 55 E. Monroe, Suite 3510, Chicago, 60603.

**GUARANTY FUND CERTIFICATE,** Number 1901, Illinois State Medical Inter-Insurance Exchange for sale. Territory 1 Class 1, Purchase Price $772. Best offer, contact Donald Gordon, M.D., Lutheran General Hospital, 1775 Dempster Ave., Park Ridge, IL 60068; Tel. (312) 696-2210.

*IMJ and ISMS are not acting as brokers or agents; this is provided as a membership service.*


## Rush University 1978 Programs in Education For Practicing Health Professionals

**April 28, 1978,** Course Director Margo Mansfield, O.T.: *Medical Audit in Occupational Therapy.* 6 hours, C.E.U.O.T. **Audience:** Occupational Therapists.

**April 29, 1978,** Course Directors R. DeWald, M.D. and M. Faut, R.N.: *Scoliosis: School Screening.* C.E.U. and A.N.A. Credit. **Audience:** School Health Nurses, Physical Education Teachers.

**May 31, 1978,** Course Directors Werner Meier, M.D. and Anne McCormick, R.N., M.S. *Infant Nutrition.* 8 hours, Category I and I.N.A. **Audience:** Pediatricians, Family Physicians, Neonatologists & Nurses.

*For further information, please write*

Harold A. Paul, M.D., M.P.H., Associate Dean, Office of Continuing Education, 600 S. Paulina Street, Chicago, IL 60612. Or telephone (312) 942-6917.

# DEPARTMENT CHAIRMAN OF MEDICINE

The Ravenswood Hospital Medical Center, located at 4550 N. Winchester Ave., Chicago, Illinois, a teaching/community 450 bed hospital, is seeking a Department Chairman of Medicine. The Hospital is affiliated with the Abraham Lincoln School of Medicine of the University of Illinois, and has an approved internal medicine residency program and an approved continuing medical education program.

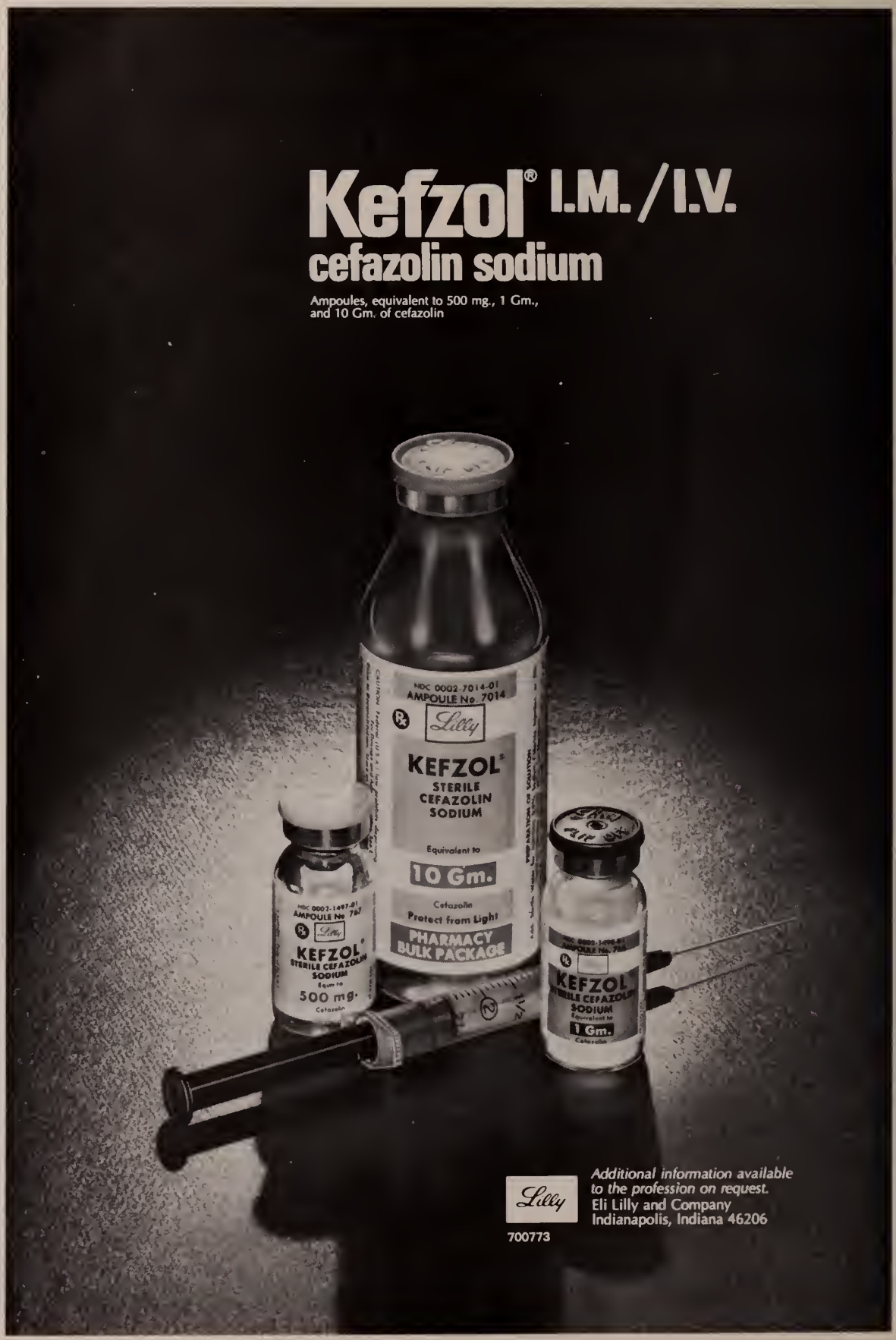
The individual for this position must be board certified in his/her area of specialty by education, or qualified with demonstrated competency in this area of specialty; and shall also have demonstrated professional and administrative abilities and possess a knowledge of education techniques. The individual must have a firm commitment to medical education, as well as to quality medical care, and shall be administratively responsible for the Department of Medicine.

The Medical Center offers a competitive salary and benefit program. Qualified applicants please submit resumes in confidence to:

**Maurice A. Colbert, M.D.**
**RAVENSWOOD HOSPITAL MEDICAL CENTER**
**4550 N. Winchester Ave.**
**Chicago, Illinois 60640**
**(312) 878-4300, ext. 342**
*An Equal Opportunity Employer*

# Kefzol® I.M./I.V.
## cefazolin sodium

Ampoules, equivalent to 500 mg., 1 Gm.,
and 10 Gm. of cefazolin




Lilly

*Additional information available to the profession on request.*
Eli Lilly and Company
Indianapolis, Indiana 46206

700773



Only Jobst supports are custom made from precise measurements of the individual extremity.

# Jobst®
# Venous Pressure Gradient® Supports

These measured, custom-made therapeutic elastic supports have carried the Jobst name to the four corners of the world. Prescription only, the supports can be engineered with counterpressures of 25, 30, 40 or 50 mm. Hg at the ankle, decreasing proximally along the venous pressure gradient. They are available in knee-length, full-leg, waist-height and lymphedema sleeve styles. The waist-height Jobst Pregnancy Leotard deserves special mention because each one is custom made with an expandable panel according to the patient's own measurements.

**Contact your local Jobst Service Center for complete details.**

## JOBST CHICAGO SERVICE CENTER

**Chicago, Illinois 60602**
Suite 2101, Pittsfield Bldg.
55 E. Washington Street
312/346-0446

# Physician Recruitment Program

*In an effort to reduce the number of towns in Illinois needing physicians, the Physician Recruitment Program and the Doctor's Job Fair, are publishing synopses in the Journal.*

*Physicians who are seeking a place to practice or who know of any out-of-state physicians seeking an Illinois residence are asked to notify the Program.*

*Any areas wishing to be listed should contact: Mrs. E. Duffy, Physician Recruitment Program, ISMS, 55 E. Monroe, Suite 3510, Chicago, 60603.*

**BRAIDWOOD:** Physician for family practice, 20 miles south of Joliet—60 miles south of Chicago. No other doctor in town of 5,000. Next door to pharmacy. Clinic provided, substantial guaranteed income for 17 hours per week. One year contract. Contact: Ron Radley, Box 795, Braidwood 60408. (815) 458-2224 or (815) 634-4900. (6)

**CANTON:** Coleman Clinic, Ltd. Population 15,000; drawing area 60,000. Twelve physicians; multi-specialty clinic. Planning expansion program. Progressive city and clinic offering outstanding opportunity to primary care physician. Guaranteed salary and excellent benefits. Contact: H. E. Crouch, 175 S. Main St., Canton, 61520. (309) 647-0201. (6)

**CASEY:** Family physician. Practice quality rural medicine having advantage of group, but independence of solo practice. New complete facilities. Financial assistance available. This is the area to work, live, and enjoy families. Superb congenial doctors & colleagues to share your work. Before you decide, come see our operation. Contact: B. F. Vondracek, Casey Medical Center, Casey, 62420. (217) 932-4061. (6)

**CHADWICK:** Rural community in picturesque Northwestern Illinois, 125 miles west of Chicago. Need for a family physician in a solo practice or possible clinical association. Office space available. Contact: Harold Frank, 411 First St., Chadwick, 61014, (815) 684-5154 or 684-5147, Allen Smith, Rural Route, Chadwick, 61014, (815) 684-5200 or 684-5152. (6)

**CHICAGO:** General Surgeon—group located in 300-bed hospital in Chicago has an immediate opening for a general surgeon. Excellent benefits and salary. Reply to Box JP, c/o Physician Recruitment Program, 55 E. Monroe, Chicago, IL. 60603. (4)

**CHICAGO:** Dr. Charles Chadbourn is looking for a doctor to take over practice immediately. Practice consists of obesity, industrial, some private and public aid patients. 7948 S. Western Ave. Call Marilyn at 436-2552 for appointment. (5)

**DeKALB:** Northern Illinois University. Need internist and chief of clinical medicine, psychiatrist and head of mental health, and primary care physicians. Competitive salaries, fringes, 9- or 12-months annual contract, good facilities, 21,200 students, near metropolitan Chicago. Contact L. W. Akers, M.D., University Health Service, NIU, DeKalb, Ill. 60115. AA/EOE Employer. (5)

**DOUGLAS COUNTY:** Population 20,000. General internist needed to serve Tuscola and surrounding area. Family practitioners needed in Villa Grove and Arcola. Twenty-five miles from Champaign and University of Illinois. 58 bed general acute hospital in Tuscola. Contact: Norm Rentz, Administrator, Jarman Memorial Hospital, 704 N. Main St., Tuscola 61953, (217) 253-3361. (6)

**FAIRFIELD:** Population 6,000. Rural area with a service population of 25,000. Seventy miles from Evansville, Indiana. Opening in medical clinic for obstetrician-gynecologist, family practitioner, or internist interested in doing family practice. Financial assistance available. Contact: Dr. Arthur Marks or Dr. Sigmund Konarski, 101 E. Center Street, Fairfield, 62837. Telephone: (618) 842-2187. (6)

**FORT MADISON, IOWA:** Openings for 2-4 FP/GP, Ped., in growing industrial city of 16,000 serving 70,000 on Mississippi River. Solo, partnership, clinic available. Substantial salary, other incentive. U. of Ia. near, excellent living area, 125 bed accredited hospital. Contact Donald A. Buckert, Fort Madison Community Hospital, Fort Madison, Ia. 52627. (319) 372-6530. (7)

**FREEPORT:** Internist-general internist or internist with sub-specialty, board certified or eligible to join multi-specialty group in community of 35,000 in Northern Illinois. Excellent salary first year then partnership. Excellent retirement and fringe benefits. Send curriculum vita and references to K. H. Shons, Business Manager, Freeport Medical Clinic, Ltd., 3103 West Stephenson Road, Freeport, 61032. (815) 235-6131 (7)

**GALESBURG:** Excellent opportunities in ENT, Family Practice, Internal Medicine, Ob-Gyn. West-central Illinois community of 40,000, manufacturing & agricultural center. Home of Knox College. Outstanding educational, recreational, and cultural environment. Financial incentives and new medical office building available. Contact: Marshal G. Maggard, President, Galesburg Cottage Hospital, Galesburg, 61401. (309) 343-8131. (6)

**HERRIN:** Population 10,000. Trade area 40,000. Located in beautiful vacationland of Southern Illinois, near major university and medical school. Family Practice and OB-Gyn needed. Solo or clinic available. Excellent financial program provided. Modern well equipped hospital. Call collect or write, Larry Feil, Herrin Hospital, Herrin, 62948—Tel. (618) 942-4710. (7)

**ILLINOIS:** The Illinois Department of Mental Health and Developmental Disabilities has opportunities in all areas of the state for psychiatrists and primary care physicians. M.D.'s and D.O.'s with Illinois licenses will be considered. Competitive salaries commensurate with training and experience; attractive fringe benefits. Contact: John T. Nelson, M.D., Coordinator of Medical Affairs, 750 South State Street, Elgin, 60120. (312) 742-1040, x321. (6)

**JACKSONVILLE:** Opportunities for family practice, internal medicine, ENT, orthopedic surgery, emergency room. Progressive 250 bed hospital, 40 member medical staff. Prosperous community with service area of 60,000, two colleges, excellent schools, 30 miles from medical school. Financial assistance, office facilities available. Contact: Bernie Gregory, Passavant Hospital, Jacksonville 62650. (217) 245-9541. (6)

**LIBERTYVILLE:** Family practice physician, general practitioner, or internist to join outpatient clinic in rapidly growing area near lakes, shopping centers, recreation areas, and easy access to Chicago theaters, museums and cultural events. Clinic consists of full auxiliary facilities, special procedure rooms and future outpatient surgical center. For information contact: Family Medical Center, Rt. 1, Box 351, Libertyville 60048, (312) 362-9097. (6)

**MENDOTA:** General practice, second physician for Wholistic Health Center of Mendota, Illinois. Innovative program with additional staff for counseling and patient education. Excellent local hospital. Future openings available in five other Wholistic Health Centers in the planning stage. Call or write: Lucy Young, M.D., 607 Tenth Ave., Mendota, 61342. (815) 539-3888 (7)

**MUNSTER:** Industrial and Emergency Room physician needed for large midwest multispecialty clinic. Trauma oriented physician only need apply. Competitive first year salary with opportunity for early equal Partnership in 60 man group. All fringes clinic paid—most liberal vacation and PG allowance. No investment required. Send CV to: Thomas R. Hofferth, Hammond Clinic, 7905 Calumet Ave., Munster, IN 46321. (219) 836-5800 (5)

**PEORIA:** Emergency physician—Unique opportunity to start on the ground floor with fee-for-service group in 550-bed medical center seeing 27,000 ER visits. Need career-minded physician for three 16-hour shifts per week with four weeks paid vacation. Compensation 57K with excellent corporate benefits plus incentive compensation. Flexible scheduling to allow individual pursuits in university town of 250,000 in Central Illinois. Contact: Hospital Emergency Physicians S.C., 221 Northeast Glen Oak, Peoria, 61636; phone 309-672-4974. (8)

**PITTSFIELD:** Family practitioners and surgeons interested in locating in rural community area needed. Population 4100; area 18,000. Excellent opportunity for some one wanting to practice in a rural community. Located between Jacksonville, Illinois and Quincy, Illinois on Highways 54 and 36. Contact Mr. Gary Deer, 217-285-2113. (5)

**PRINCETON:** Family physician & internist—population 10,000, lovely community with excellent school and recreational facilities. Excellent hospital facility built in early 1970's. New office building attached to hospital will be completed in Spring of 1978. Specialties of internal medicine, OB, orthopedics, pediatrics, surgery, and urology available to complement the family physician. Contact: Harold L. Autrey, 530 Park Avenue East, Princeton 61356. (815) 875-2811. (6)

**SPRINGFIELD:** Family practitioners — Springfield Community Hospital is looking for you to begin private practice in our new multi-specialty Community Medical Plaza. We offer an attractive package to help you get started. If interested, contact: W. H. Fields, Springfield Community Hospital, 5230 S. 6th St., Springfield, 62703. (217) 529-7151. (6)

**UNION COUNTY:** Population 17,000. Clinic and office facilities available for family practitioner and physician of internal medicine. Special Care Unit under construction in County Hospital. Nearby cities of Carbondale and Cape Girardeau 25 miles away. Recreational facilities plentiful. Contact: E. A. Helfrich, 517 N. Main, Anna, 62906 AC 618-833-5155. (7)


**LOW-COST GROUP INSURANCE ANOTHER ISMS MEMBERSHIP PRIVILEGE**

**THE GROUP DISABILITY PLAN** ● Provides up to $1,732.00 monthly in the event of disability caused by Accident or Sickness. ● Special Guaranteed renewal feature. ● Protect your income and security.

**BUSINESS OVERHEAD EXPENSE PLAN** ● Pays your office overhead expense when disability strikes. ● Premiums are Tax Deductible. ● Pays in Addition to the Disability Plan Benefits.

**THE BASIC MAJOR MEDICAL EXPENSE PLAN** ● In or out of Hospital Benefits up to $25,000.00 per Disability. ● Up to $100.00 Daily Hospital Room and Board maximum. ● Subject to choice of deductible and 80% coinsurance.

**EXCESS MAJOR MEDICAL PLAN** ● Provides up to $250,000 for Medical Expenses. ● Supplements **any** Basic Major Medical Plan and has a $25,000 deductible. ● Low group rates. ● Truly **catastrophic coverage.**

FOR INFORMATION, ASSISTANCE & DETAILS CONTACT:

Administrators:
PARKER, ALESHIRE & COMPANY
ESTABLISHED 1901
Insurance

9933 N. Lawler Avenue
Skokie, Illinois 60076
Phone: 312-679-1000

# Angina freedom fighter...



Freedom from anginal pain



Freedom from anginal fear

1. Taken sublingually, Cardilate® (erythrityl tetranitrate) begins to work within 5 minutes, eliminating or reducing frequency and severity of anginal pain for up to two hours.
2. Fear of pain, a major deterrent to achieving acceptable (and desirable) levels of activity, including sex, may be allayed with Cardilate. Effective prophylaxis and improved exercise tolerance help toward normalizing the lives of anginal patients.

# Cardilate®
## (erythrityl tetranitrate)

**dilate® (erythrityl tetranitrate)**
ICATIONS: For the prophylaxis and long-term treat-
t of patients with frequent or recurrent anginal pain
reduced exercise tolerance associated with angina
oris, rather than for the treatment of the acute attack
ngina pectoris, since its onset is somewhat slower
that of nitroglycerin.
CAUTIONS: As with other effective nitrites, some fall
ood pressure may occur with large doses.
tion should be observed in administering the drug to
nts with a history of recent cerebral hemorrhage,
use of the vasodilation which occurs in the area.
ugh therapy permits more normal activity, the
nt should not be allowed to misinterpret freedom
anginal attacks as a signal to drop all restrictions.
EFFECTS: No serious side effects have been
rted. In sublingual therapy, a tingling sensation (like
of nitroglycerin) may sometimes be noted at the
t of tablet contact with the mucous membrane. If
ctionable, this may be mitigated by placing the tablet
e buccal pouch. As with nitroglycerin or other effec-
nitrites, temporary vascular headache may occur
g the first few days of therapy. This can be con-
d by temporary dosage reduction in order to allow
stments of the cerebral hemodynamics to the initial
ed cerebral vasodilation. These headaches usually
pear within one week of continuous therapy but
be minimized by the administration of analgesics.
gastrointestinal disturbances occur occasionally
larger doses and may be controlled by reducing the
temporarily.
HOW SUPPLIED: 10 mg chewable scored tablets,
bottle of 100. Also 5, 10 and 15 mg oral/sublingual
scored tablets in bottles of 100. 10 mg oral/
sublingual scored tablets also supplied in bottles
of 1,000.
Also available: Cardilate®-P brand Erythrityl
Tetranitrate with Phenobarbital* Tablets
(Scored).
(*Warning—may be habit-forming.)

**Burroughs Wellcome Co.**
Research Triangle Park
North Carolina 27709

# Clinics for Crippled Children Listed for April

Thirty-five clinics for Illinois' physically handicapped children have been scheduled for February by the University of Illinois, Division of Services for Crippled Children. The Division will count twenty-five general clinics providing diagnostie orthopedic, pediatric, speech and hearing examination, along with medical social and nursing services. There will be nine special clinics for children with cardiac conditions and one for children with cerebral palsy. Any private physician may refer to or bring to a convenient clinic any child or children for whom he may want examination or consultative services.

April 4 Quincy—Blessing Hospital
April 4 Park Ridge Cardiac—Lutheran General Hospital
April 5 Cairo—Public Health Department
April 5 Hinsdale—Hinsdale Sanitarium
April 6 Effingham—St. Anthony Memorial Hospital
April 6 Sterling—Community General Hospital
April 6 Lake County Cardiac—Victory Memorial Hospital
April 7 Division Cardiac—U. of I. at the Medical Center
April 10 Peoria Cardiac—St. Francis Hospital
April 11 Peoria—St. Francis Hospital
April 12 Champaign-Urbana—McKinley Hospital
April 12 Joliet—St. Joseph's Hospital
April 13 Metropolis—Massac Memorial Hospital
April 13 Springfield—St. John's Hospital
April 13 Kankakee General—St. Mary's Hospital
April 14 Chicago Heights Cardiac—St. James Hospital
April 17 Maywood—Loyola Medical Center
April 18 Rock Island—Moline Public Hospital
April 18 Decatur—Decatur Memorial Hospital
April 18 East St. Louis—Christian Welfare Hospital
April 19 Rockford—St. Anthony's Hospital
April 19 Springfield Ped-Neuro—St. John's Hospital
April 19 Chicago Heights General—St. James Hospital
April 19 Aurora MM—St. Joseph Mercy Hospital
April 20 Rockford—Rockford Memorial Hospital
April 20 Bloomington—Mennonite Hospital
April 20 Elmhurst Cardiac—Memorial Hospital of DuPage County
April 21 Kankakee Cardiac—St. Mary's Hospital
April 24 Peoria Cardiac—St. Francis Hospital
April 25 Peoria—St. Francis Hospital
April 25 Belleville—St. Elizabeth's Hospital
April 26 Centralia—St. Mary's Hospital
April 27 Litchfield—St. Francis Hospital
April 28 Chicago Heights Cardiac—St. James Hospital
April 28 Evanston—St. Francis Hospital

The Division of Services for Crippled Children is the official state agency established to provide medical, surgical, corrective and other services and facilities for diagnosis, hospitalization and after-care for children with crippling conditions or who are suffering from conditions that may lead to crippling. In carrying on its program, the Division works cooperatively with local medical societies, hospitals, the Illinois Children's Hospital-School, civic and fraternal clubs, visiting nurse association, local social and welfare agencies, local chapters of the National Foundation and other interested groups. In all cases, the work of the Division is intended to extend and supplement, not supplant, activities of other agencies, either public or private, state or local, carried on in behalf of crippled children.

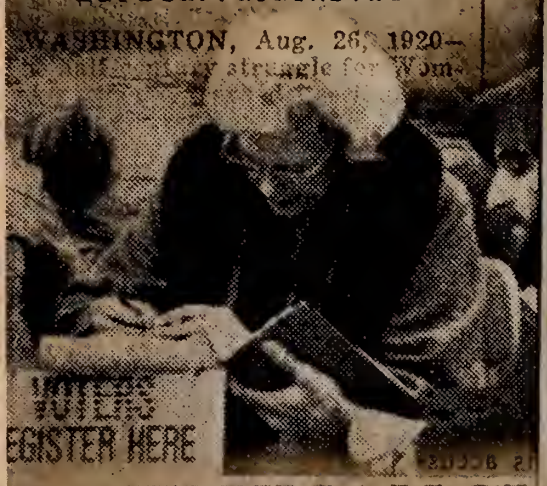
# COLBY PROCLAIMS WOMAN SUFFRAGE

Signs Certificate of Ratification at His Home Without Women Witnesses.

MILITANTS VEXED AT PRIVACY.

Wanted Movies of Ceremony, But Both Factions Are

WASHINGTON, Aug. 26, 1920—




# Social Security Bill Is Signed, Gives Pensions to Aged, Job

## Roosevelt Approves Message Intended to Benefit 30,0 Persons When States Adopt Cooperating Laws–He the Measure 'Cornerstone' of His Economic Progr

WASHINGTON, Aug. 1 The Social Security Bill, p a broad program of unemp insurance and old age and counted upon to ben 20,000,000 persons, becam day when it was signed b dent Roosevelt in the pre those chiefly responsible ting it through Congre s.

Mr. Roosevelt calle the "the cornerstone in which is being me s

# SENATE APPROVES 18-YEAR OLD VOTE IN ALL ELECTIONS

Amendment to Constitution is Sent to House, Where Passage is Expected

WASHINGTON, March 10, 1971—The Senate approved today 94 to 0, and sen

# TRUMAN CLOSES TED NATIONS CONFEREN ITH PLEA TO TRANSLATE CHARTER INTO DEEDS

## NEW WORLD HOPE

President Hails 'Great Instrument of Peace,' Insists It Be Used

HISTORIC LANDMARK

Meeting Gives Standing Ovation as Executive Pictures Peace Gain

"If we fail to use it," he declared to the solemn final meeting of the delegates, 'we shall betray all of those who have died in order that we might meet here in freedom and safety to create it.'

"If we seek to use it selfishly—for the advantage of any one nation or any small group of nations—we shall be equally guilty of that betrayal."

Fervent Interpolation

The President, speaking in the auditorium of the War Memorial Opera House, built in memory of sons of the Golden Gate city who gave their lives in the first World War, in which he himself served, seemed to give unconscious expression to the solemn feeling of the occasion when, at the outset of his speech, he interpolated the words, half a hope, half a prayer:

"Oh, what a great day this can be in history!"

Just before the plenary session

# UL IGNI the Draf Ends No

WASHINGTON, Jan. 27, 1973—"With the signing of the peace agreement in Paris today, and after receiving a report from the



# PATIENT PACKAGE INSERTS: A CONCEPT WHOSE TIME HAS COME?

*The consumer's right to know is an irreversible and desirable trend of the Seventies. It extends, and properly, to a patient's right to know more about his or her prescription medications. One way, gaining favor, is through patient package inserts. Wisely-prepared and properly distributed when medically indicated, they could markedly improve patient knowledge and drug therapy—laudable goals by anyone's standards.*

*The PMA endorses these goals and will work with government, the health professions and consumers to achieve them.*

## The Advantages

The concept holds promise of benefits: better patient understanding of the product prescribed, better adherence to the treatment plan, and more awareness of possible side reactions.

Every doctor has had patients who fail to finish antibiotic regimens because they feel better. Some patients assume that if one tranquilizer or analgesic is good, two may be twice as good. Still others fail to report dizziness while on antihypertensive therapy —and so on.

Problems like these might arise less often if the patient received written information in addition to verbal instructions. Some studies suggest that patients are more receptive to such materials, and they more often understand the verbal instructions and follow them, when inserts are used.

## The Disadvantages

There are also some potential problems. Obviously, the inserts must be clearly phrased, without extraneous or complex detail. How much information is enough? How can it be kept current? Should all patients receive the same information? Should inserts be included with all drugs? Should only potential problems be listed or are patients better off with a "fair balance" presentation that describes usefulness as well as drawbacks?

These and similar questions require answers, since model inserts have yet to be properly developed and tested. Despite the need for these studies, the FDA is proceeding prematurely with inserts on selected products. We think the Congress is the only place where the matter can be given the proper legal status and direction, particularly since it represents a conceptual change in the legal, medical and social framework of the nation's prescription drug information system.

## The Solution

The PMA believes that carefully-devised pilot studies of various kinds of inserts are needed. They should be developed and implemented with full participation by doctors, pharmacists, consumers, communications experts and the drug industry. Such studies will provide reliable pathways to follow, so that inserts will be useful aids to medical practice.

And particularly we think that you should be closely involved in this debate and in these studies and decisions. Otherwise, people with less experience and qualifications may control the purposes, content and use of a tool with considerable promise for improved patient care. It could make a difference in your practice tomorrow, and more importantly, in the health of your patients.

PMA
THE PHARMACEUTICAL MANUFACTURERS ASSOCIATION
1155 FIFTEENTH ST. N. W. WASHINGTON, D. C. 20005

# *EKG*

*(Continued from page 180)*

**Answers: 1. D. 2. A. B. C. D. E.**

The ECG rhythm strip shows a multifocal atrial tachycardia or a chaotic atrial tachycardia. The criteria proposed for the diagnosis of this arrhythmia are more than two ectopic P waves with different P-P cycles and a tachycardia of 100 to 250 beats per minute. There are also varying PR intervals and blocked or non-conducted P waves with an isoelectric line between P waves. The presence of these P waves can be seen by careful examination of the rhythm strip. Atrial flutter would have regular P waves and junctional tachycardia would have regular QRS waves. This interesting arrhythmia is frequently associated with chronic pulmonary disease and coronary artery disease. Congestive heart failure may be part of the clinical picture. Digitalis may be helpful but will often not convert the arrhythmia to sinus rhythm. Successful treatment involves good treatment of the underlying disease process. The arrhythmia is found in seriously ill patients and has been associated with high mortality rates. Depending upon the results of the lab data, all of the treatment modalities might be used here. Our patient did require intubation and respiratory assistance because he was in respiratory failure with $CO_2$ retention. Moderate congestive heart failure was also present. After these were controlled, the patient survived. For further reading, see Lipson and Naimi: *Circulation* 42:397, 1970.

★

*Specialized Service*

IN

PROFESSIONAL LIABILITY INSURANCE

*is a high mark of distinction*

THE

MEDICAL PROTECTIVE COMPANY

FORT WAYNE, INDIANA

*Professional Protection Exclusively since 1899*

CHICAGO AREA OFFICE:

T. J. Pandak, J. C. Kunches, L. R. Gannan, and W. G. Prangle, Representatives

814 Commerce Drive, Suite 101B, Oak Brook, Illinois 60521 (312) 325-7314

SPRINGFIELD OFFICE: W. J. Nattermann, Representative

426½ South Fifth Street, Springfield 62701 (217) 544-2251

**You are invited to attend a live telecast symposium . . .**

# Depression Today

# Confident Clinical Office Management

Wednesday,
April 5, 1978

**PROGRAM CHAIRMAN:** DANIEL X. FREEDMAN, M.D.
The University of Chicago/The Pritzker School of Medicine

**PARTICIPANTS:**

JAN FAWCETT, M.D.
Rush-Presbyterian/St. Luke's Medical Center, Chicago, Illinois
ROBERT W. GIBSON, M.D.
Sheppard & Enoch Pratt Hospital, Towson, Maryland
LEO E. HOLLISTER, M.D.
Stanford University School of Medicine, Palo Alto, California
HEINZ E. LEHMANN, M.D.
McGill University Faculty of Medicine, Montreal, Canada
JOSEPH J. SCHILDKRAUT, M.D.
Harvard Medical School, Boston, Massachusetts
ROGERS J. SMITH, M.D.
University of Oregon Health Science Center & private practice, Portland, Oregon
CARROLL L. WITTEN, M.D.
University of Louisville School of Medicine & private practice, Louisville, Kentucky

**SCIENTIFIC PROGRAM:**

- This Symposium focuses on a practical approach to recognizing and diagnosing depression — an approach which can be integrated into the physician's everyday clinical practice.
- Special emphasis is given to the treatment aspects of depression.
- This program also develops a fuller understanding and appreciation of the importance of the proper management of depression.

## THIS TELECAST WILL BE SHOWN IN THE FOLLOWING CITIES:

| | | |
|---|---|---|
| ATLANTA | HOUSTON | PHILADELPHIA |
| BOSTON | LOS ANGELES | ST. LOUIS |
| CHICAGO | MIAMI | SAN FRANCISCO |
| DALLAS | NEW ORLEANS | SEATTLE |
| DENVER | NEW YORK CITY | WASHINGTON, D.C. |

## TIME ZONES

1:00 p.m. Pacific
2:00 p.m. Mountain
3:00 p.m. Central
4:00 p.m. Eastern

Co-sponsored by the Department of Psychiatry, The University of Chicago/The Pritzker School of Medicine and C.M.E. Communications, Inc.

Produced and developed by C.M.E. Communications, Inc., in cooperation with World Health Information Services, Inc., Under an educational grant from Merrell-National Laboratories, Inc.

**Endorsed by:**
Psychiatry Education Branch of the
National Institute of Mental Health

**ACCREDITATION:**
Approved for 3 credit hours in Category 1
for the Physician's Recognition Award
of the American Medical Association.

**For copies of program/invitation or additional information, contact:**

World Health Information Services, Inc.
505 Park Avenue, New York, New York 10022
Telephone: 800, 223-1848
212, 751-5737 in New York

**RETURN TO:**
World Health Information Services, Inc.
505 Park Avenue, New York, New York 10022

☐ Send full Program/Invitation.
☐ I plan to attend.

Name (please print)

Mailing Address

City/State Zip Code

# Department Policy Regarding Amygdalin-Laetrile

*Following is the official Illinois Department of Public Health policy regarding Amygdalin-Laetrile. The Act requires that three reports be filed with IDPH for each patient receiving this treatment. These reports, entitled "Physician's Affidavit," Patient's Affidavit," and "Report of Treatment" are a mechanism to fulfill another requirement of the Act: IDPH must file an annual report with the Governor and General Assembly summarizing results of the use of Amygdalin-Laetrile as a treatment of cancer. Single copies of the forms are available for review from the IMJ offices.*

Legislation to remove Amygdalin-Laetrile from the "New Drug" provisions of the Illinois Food, Drug and Cosmetic Act was enacted December 12, 1977, as Public Act 80-1096.

Although the law is titled "An Act in relation to the drug commonly known as Laetrile," the referenced drug may be referred to as either Laetrile or Amygdalin according to an opinion of the Office of the Attorney General. Opinion #S-1331 dated January 19, 1978, states, in summary, that "Public Act 80-1096 cannot be construed to apply only to Amygdalin, but must be construed in accordance with the intent of the General Assembly to apply to Laetrile as well."

Public Act 80-1096 effectively removes Amygdalin-Laetrile from the requirement which applies to all other new drugs, i.e., that the drug must be proven "safe and effective" before offered for public use. The safe and effective provision assures that the patient is protected because dangerous and worthless drugs cannot be marketed and the physician is protected in the knowledge that the drugs that he prescribes for a course of therapy are safe and effective for the purpose intended.

The reference drug, whether called Amygdalin or Laetrile, is imprecise in both name and composition. The term Laetrile is a generic term which applies to a group of compounds of unknown number. Laetrile has no set composition; it varies depending upon the manufacturer and has no pharmacopeial standard. Since Laetrile is not uniform in composition and without a standard, the mechanism for assuring the safety, purity and quality of the drug is missing.

The labeling of an approved drug must meet the requirement that it be intended solely for use under conditions prescribed, recommended or suggested in the labeling with respect to the drug. Conditions for use include, among other things, recommended useage, how it is to be administered, and therapeutic instructions. Because of the variability in, and uncertainty about, the composition of Laetrile, the requirement for truthful and informative labeling, as it applies to approved drugs, cannot be applied to Laetrile.

Inasmuch as:

1. Laetrile as it is offered for sale in the treatment of cancer is not one standardized preparation, but several different non-uniform ones, and;
2. Laetrile and Amygdalin are not the same chemical compound, and;
3. Proponents of Laetrile do not agree as to the identity of the chemical compound bearing that name, and;
4. No adequate and well-controlled clinical investigations have been carried out, and;
5. Overwhelming evidence demonstrates that, among experts in the evaluation of the safety and effectiveness of cancer chemotherapy, Laetrile and Amygdalin are not recognized as safe or effective, therefore:

The Illinois Department of Public Health assumes no responsibility for the safety, efficacy, quality, purity, labeling, or any other requirement of approved "New Drugs" in regard to the compound Amygdalin-Laetrile.

Paul Q. Peterson, M.D.
Director, Ill. Dept. of Public Health

# Doctor's News

**LICENSE RENEWAL DEADLINE**—July 1, 1978, is the renewal date for all medical licenses. The Illinois Department of Registration and Education will distribute renewal notices to all registrants in April. If you have moved and have not forwarded your new address to R&E, it is advised that you do so immediately.

**LAETRILE LAW CLARIFICATION**—The Illinois Attorney General has ruled that both amygdalin and laetrile are exempt from provisions of the Illinois Food, Drug and Cosmetic Act. The Illinois Department of Public Health statement (see text on facing page) has maintained that although amygdalin is an identifiable chemical compound, laetrile cannot be standardized as to purity, while both terms are used interchangeably in the law. The statement denies responsibility "for the safety, efficacy, quality, purity, labeling, or any other requirement of approved 'New Drugs' in regard to the compound Amygdalin-Laetrile."

At the February meeting of the ISMS Board of Trustees, the Board voted to resist future legislative efforts to exempt specific substances from existing laws. They recommended that physicians administering laetrile maintain copies of affidavits and other required documents in their files and patient records. Copies also must be forwarded to IDPH. The Board cautioned physicians that *the drug should be administered to minors only upon court order.*

**GENERIC DRUG LISTING**—IDPH has announced that the first formulary of drug products approved for substitution under the new Illinois Generic Drug Substitution Act will be ready for distribution by June 1, 1978. Recommendations from the Generic Drug Technical Advisory Council will be used to develop the list. The law becomes effective July 1.

**OCCUPATIONAL MEDICINE**—The 1978 American Occupational Health Conference will be held April 10-14 in New Orleans, Louisiana. The conference, which comprises the annual meetings of the American Occupational Medical Association and the American Association of Occupational Health Nurses, includes scientific sessions carrying postgraduate CME credit for attending physicians. For further information, contact Howard N. Schulz, Conference Manager, American Occupational Health Conference, 150 N. Wacker Drive, Chicago 60606.

**UTILIZATION REVIEW**—The American College of Utilization Review Physicians will hold their first National Conference at the Chicago Ritz-Carlton, April 28-30. The theme will be "The Impact of Consumerism on Quality Health Care." Further information on the conference, which has been co-sponsored by the National Association of Utilization Review Coordinators, may be obtained by writing Mrs. Betty Hammon, Executive Secretary, ACURP, 1108 N. Second Street, Harrisburg, PA 17102.

**NUTRITION SYMPOSIUM ANNOUNCED**—The seventh annual symposium on nutrition and food technology will be held April 18 at the Chicago Pick Congress Hotel. "Our Changing Society and its Effect on Food Usage" is cosponsored by the Chicago Nutrition Association, the Chicago Section of the Institute of Food Technologists and ISMS. For further information, please write: Nutrition Symposium, Jacqueline Pearce, Quaker Oats Company. John Stuart Research Labs, 617 W. Main Street, Barrington, IL 60010.

**AGING—1978: POLITICAL AND ECONOMIC REALITIES**—The annual conference on aging, sponsored by the Illinois Association of Homes for the Aging, will be held May 9 and 10. The conference will consider viable means to improve the quality of life for older persons in modern society. For further information, please contact the IAHA Institute on Aging, 3300 West Peterson Avenue, Chicago, IL 60659, or telephone (312) 583-9850.

**THE FAMILY** is the subject of the fourth AMA National Congress devoted to "Improving the Quality of Life." ISMS is a cosponsor of the meeting, scheduled for April 17-19 at the Chicago Conrad Hilton Hotel. Congress planners seek to bring a more acute awareness of the family both as a social unit and a dynamic paradigmatic influence. For further information, please contact Charles W. Macenski at the AMA, 535 N. Dearborn Street, Chicago 60610.

**PHYSICIANS IN THE NEWS**—Former ISMS president **Edward A. Piszczek, M.D.,** received Loyola University's esteemed Siedenburg Award at the Alumni Association silver anniversary celebration February 11. Doctor Piszczek, an internationally recognized authority in contagious disease and preventive medicine, has been a member of the Loyola University Stritch School of Medicine faculty for 44 years. The award, "for extraordinary contributions to the well-being of the University and its graduates," was given jointly to Doctor Piszczek, his wife, Dorothy and daughter, Anna. Doctor Piszczek, ISMS president in 1964-65, is a member of the Illinois Delegation to the AMA.

**Mohammad N. Akhter, M.D.,** Springfield, has been named chairman of the AMA Ad Hoc Committee on Foreign Medical Graduate Affairs and **Carmen T. Ciatteo, M.D.,** Lockport, will serve on the AMA Advisory Committee to Improve Medical Care and Health Services in Correctional Institutions. . . .

**Jack D. Clemis, M.D.,** Wilmette, is the new secretary of the American Academy of Ophthalmology and Otolaryngology. Doctor Clemis is an associate professor in the department of Otolaryngology and Maxillofacial Surgery at Northwestern University Medical School and chief of Otolaryngology and the Residency Program at Mercy Hospital and Medical Center. . . . Chicago physician **Reuben C. Balagot,** chairman of the Department of Anesthesiology at the University of Health Sciences/The Chicago Medical School, has received a unique honor from the Philippine government. President Fernando Marcos presented the 1976 Outstanding Filipino Overseas Award in Medical Research to Doctor Balagot for his work in the field of anesthesiology. . . . **Robert C. Stepto, M.D.,** Chicago, was recently inaugurated to the presidency of the U.S. Section of the International College of Surgeons.

The 1977 Institute of Medicine of Chicago Joseph A. Capps Prize for scientific research was awarded to Oak Park physician **William S. Konetzki,** The prize was established in 1931 and is open to graduates of recognized Chicago medical schools within five years after completion of internship or one year of laboratory work. . . . **Col. James A. Sandrolini, M.D.,** Aurora, has been elected president of the Alliance of Air National Guard Flight Surgeons.

Recent hospital medical staff elections include **Felix A. Krock, M.D., Lee A. Malmed, M.D.** and **James J. Milford, M.D.,** all of Arlington Heights, as president, vice president and secretary-treasurer at Northwest Community Hospital. . . . **Allan Charles, M.D.,** Chicago, is the new medical staff president at Michael Reese Hospital and Medical Center. **Jerome S. Mehlman, M.D.,** Chicago, and **Arnold Tatar, M.D.,** Highland Park, will serve as president-elect and secretary-treasurer. . . . **Ulisse P. Cucco,** Northbrook, is the new president of the Holy Family Hospital medical-dental staff. **George Nelson, M.D.,** Northbrook, is vice president and **John Hastings, M.D.,** Park Ridge, will serve as secretary-treasurer.

## *President's Page*



# *Tonic or Snake Oil?*

The hucksterism of the medicine side show apparently is returning to the American scene. Only this time the snake oil salesman is none other than HEW Secretary Joseph Califano.

Later this year, Secretary Califano is expected to offer the Carter Administration's wonder elixir for medical care woes—national health insurance. This tonic will be touted as the answer for all that ails the U.S. health care system. In reality, it will prove to be the acid that corrodes our great system.

In any new government program, Administration planners refuse to accept the blame if the scheme is failing. They are prone to ignore the fact that their original concepts may have been wrong. Instead, the consensus is that the program is floundering because it is too small.

National health insurance will be no exception. If Congress implements the government's proposal, we can expect its continued expansion until the Administration is promising the American public the utopian ideal of free medical care for all.

The public already has been fooled too many times by government promises of paradise. Hopefully, citizens are beginning to consider the drawbacks of a further expansion of the welfare state. We must encourage our patients to spurn the latest Carter Administration overtures and tell their Congressman to reject further federal involvement in the private sector.

George T. Wilkins, Jr., M.D.

# *Clinical experience & continuing confidence*

KAON® ELIXIR was introduced in **1954**, followed by KAON® TABLETS in **1963.** Decades of clinical experience indicate acceptability, effectiveness, and safety in the majority of patients; should abdominal pain occur, therapy should be discontinued. Both have been taken by patient after patient, day after day, year after year, to correct potassium deficiencies. Both have consistently demonstrated their value when diet alone is inadequate for potassium replacement.

## Kaon® Elixir
(potassium gluconate)

## Kaon® Tabs
(potassium gluconate)

BRIEF SUMMARY
**Kaon Tablets/Kaon Elixir**

**KAON® (potassium gluconate) TABLETS**

**Description:** Each sugar-coated tablet supplies 5 mEq. of elemental potassium (as potassium gluconate 1.17 Gm.). Kaon Tablets are sugar coated, not enteric coated, which favors dissolution in the stomach and absorption before reaching the small intestine where the lesions with enteric potassium chloride have occurred. The sugar coating merely adds to palatability and ease of swallowing, not to delay absorption as does the enteric coating.
**Indications:** Oral potassium therapy for the prevention and treatment of hypokalemia which may occur secondary to diuretic or corticosteroid administration. It may be used in the treatment of cardiac arrhythmias due to digitalis intoxication.
**Contraindications:** Severe renal impairment with oliguria or azotemia, untreated Addison's disease, adynamia episodica hereditaria, acute dehydration, heat cramps and hyperkalemia from any cause.
**Warning:** There have been several reports, published and unpublished, concerning nonspecific small-bowel lesions consisting of stenosis, with or without ulceration, associated with the administration of enteric-coated potassium tablets alone or when they are used with nonenteric-coated thiazides or certain other oral diuretics. These small-bowel lesions have caused obstruction, hemorrhage and perforation. Surgery was frequently required and deaths have occurred. Available information tends to implicate enteric-coated potassium salts, although lesions of this type also occur spontaneously. Therefore, coated potassium-containing formulations should be administered only when indicated and should be discontinued immediately i abdominal pain, distention, nausea, vomiting, or gastrointestinal bleeding occur. Coated potas sium tablets should be used only when adequate dietary supplementation is not practical.
**Precautions:** In response to a rise in the concentration of body potassium, renal excretion of the ion is increased. With normal kidney function, it is difficult, therefore, to produce potassium intoxication by oral administration. However, potassium supplements must be administered with caution, since the amount of the deficiency or daily dosage is not accurately known. Frequent checks of the clinical status of the patient, and periodic ECG and/or serum potassium levels should be made. High serum concentra-

*Time is the test of all things*



tions of potassium ion may cause death through cardiac depression, arrhythmias or arrest. This drug should be used with caution in the presence of cardiac disease.

In hypokalemic states, especially in patients on a salt-free diet, hypochloremic alkalosis is a possibility that may require chloride as well as potassium supplementation. In these circumstances, Kaon (potassium gluconate) should be supplemented with chloride. Ammonium chloride is an excellent source of chloride ion (18.7 mEq. per Gram), but it should not be used in patients with hepatic cirrhosis where ammonium salts are contraindicated. Other sources for chloride are sodium chloride and Diluted Hydrochloric Acid, U.S.P.

It should also be kept in mind that ammonium cycle cation exchange resin, sometimes used to treat hyperkalemia, should not be administered to patients with hepatic cirrhosis.

**Adverse Reactions:** Nausea, vomiting, diarrhea and abdominal discomfort have been reported. The symptoms and signs of potassium intoxication include paresthesias of the extremities, flaccid paralysis, listlessness, mental confusion, weakness and heaviness of the legs, fall in blood pressure, cardiac arrhythmias and heart block. Hyperkalemia may exhibit the following electrocardiographic abnormalities: disappearance of the P wave, widening and slurring of QRS complex, changes of the S-T segment, tall peaked T waves, etc.

**Overdosage:** Potassium intoxication may result from overdosage of potassium or from therapeutic dosage in conditions stated under "Contraindications." Hyperkalemia, when detected, must be treated immediately because lethal levels can be reached in a few hours.

**KAON® (potassium gluconate) ELIXIR**

**Description:** Each 15 ml. (tablespoonful) supplies 20 mEq. of elemental potassium (as potassium gluconate, 4.68 Gm.) with saccharin and aromatics. Alcohol 5%.

**Indications:** See Kaon Tablets.

**Precautions:** See Kaon Tablets.

In hypochloremic alkalosis, potassium replacement with potassium chloride (e.g., Kaochlor® 10% Liquid) may be more advantageous than with other potassium salts.

**Adverse Reactions:** See Kaon Tablets.

**Overdosage:** See Kaon Tablets.

**WARREN-TEED**
LABORATORIES, INC.
DIVISION OF **ADRIA LABORATORIES INC.**
COLUMBUS, OHIO 43215

# *Viewbox*

*(Continued from page 182)*



**Figure 2**



**Figure 3**

**DIAGNOSIS:** *Appendiceal abscess*

In the initial examination one notes a dilated spindled ureter at the junction of the middle and lower third of the right ureter which occurs in inflammatory bowel disease. In addition, a mass is noted compressing the cecum. Immediately above the bladder is a collection of extraluminal gas which is rather subtle in its presentation. Following a barium enema there is marked compression of the sigmoid and cecum with a large air fluid level seen on decubitus examination in the collection of extraluminal gas. This represents a pelvic abscess as a result of a ruptured appendicitis. A preferential collection site for pus is in the cul de sac and in the lateral paravesical areas. It is very important to recognize the radiographic signs on the IVP, as the patient's dysuria is in this case, a misleading fact. A recognition of the extraluminal gas collection with an air fluid level should alert one to the diagnosis of a large pelvic abscess. This information assists the surgeon in his approach.


School Screening For Scoliosis



*A one-day course for school nurses and physical education teachers sponsored by Rush-Presbyterian-St. Luke's Medical Center Spine Surgery Section, Department of Orthopedic Surgery.*

*For further information, please contact Harold A. Paul, M.D., M.P.H., Associate Dean, Office of Continuing Education, 600 S. Paulina St., Chicago, IL 60612; (312) 942-6917. Advance registration is required.*

*April 29, 1978*

*C.E.U. and A.N.A. Credit Available*



# report

Illinois Society
American Association of Medical Assistants

# "Preferred Investment: Education"

"Governor Thompson declares "MEDICAL ASSISTANT WEEK" in Illinois from April 23-30, 1978," states the official proclamation.

The 22nd Annual Meeting of the Illinois Society, American Association of Medical Assistants will officially open on Thursday, April 27, 1978. At 8:00 p.m., ribbon cutting ceremonies in Skokie at the North Shore Hilton Hotel will signal its beginning. They will be followed by entertainment and a welcome party.

A combination of Association business and outstanding educational programs will gather approximately 300 Medical Assistants from all parts of Illinois. Distinguished guests from the medical community will honor us at the opening of the House of Delegates on Friday at 10:00 a.m.

Saturday's all day educational session will begin at 9:00 a.m. The first session, "What Leaders Need To Know: Managing Time—The Irreplaceable Resource," will be conducted by Roger Fritz, Ph.D., president of Organizational Development Consultants in Naperville, Illinois.

The values of proper nutrition ("How to Contend with the Diet Barrage") will be presented by Phillip L. White, Sc.D., Director of Food and Nutrition, American Medical Association.

Mr. E. G. Metcalf, a special representative trainer from Burroughs Wellcome pharmaceutical company, will next address the group. Mr. Metcalf's talk is entitled "All Drugs Are Not Equal."

Continuing education—the primary goal of achieving certification—plays an important role in all the educational seminars. A special Self Assessment Test will be offered on Saturday afternoon for future Certified Medical Assistants.

Application has been filed with the American Association of Medical Assistants for consideration of awarding Continuing Education Units (CEU) Credits for portions—or all—of this program.

**Social Events**

Mrs. Vivian Kraft, CMA-AC, President, AAMA Illinois Society will greet Chapter Presidents during the annual Presidents' Banquet, Friday, 8:00 p.m.

Special recognitions are scheduled during the Awards Luncheon, Saturday noon. The Inaugural Banquet, 7:30 p.m. Saturday, will culminate the preceeding year's accomplishments and will honor the incoming officers during the impressive Installation Banquet Ceremonies.

To conclude the meeting, Mrs. Mabel Ann Veech, Trustee, AAMA, Louisville, Kentucky, is scheduled guest speaker at the Farewell Breakfast on Sunday at 9:00 a.m.

Advance registration package (prior to April 10th) : $40.00 members and $50.00 non-members. The package includes all educational sessions, Welcome Party, banquets on Friday and Saturday, breakfasts on Saturday and Sunday and Saturday's luncheon.

A special registration rate of $5.00 for medical assistant students has been allocated to encourage student participation at all educational sessions, including continental breakfast Saturday morning.

Single function tickets are available. Contact Mrs. Synobia Payne, Convention Chairman, 312-667-1330 or 312-264-5651. Please make all checks payable to: AAMA, Illinois Society Convention Fund c/o Mrs. Synobia Payne, 10022 S. Princeton Ave., Chicago, Ill. 60628. Enclose payment with the form below to assure your reservation.

---

**Preferred Investment: Education**
**April 27-30, 1978**
**North Shore Hilton, Skokie**

Full Advance Package, (before April 10) . Members ($40.00) ; Non-Members ($50.00) .

Name _____

Address _____

AAMA Member? _____

Chapter _____

LIBRARY
MAR 28 1978
NEW YORK ACADEMY OF MEDICINE

IMJ
Illinois Medical Journal

# YOUR ADVERTISERS

*Our advertisers serve the Medical Profession and support your Journal. All advertisers are approved by your Journal Committee. It will help you and your society to mention your Journal when writing them.*

## Space Representatives

United Media Associates, Inc., 16 Bruce Park Avenue, Greenwich, Conn. 06830

## Pharmaceuticals


174-176 Boehringer Ingelheim
*Catapres*

186 Breon Laboratories
*Bronkodyl*

238-239 Burroughs Wellcome Company
*Cardilate*

Cover 2 Burroughs Wellcome Company
*Empirin Compound with Codeine*

189-190 Geigy Pharmaceuticals
Div. of Ciba-Giegy Corp.
*Tofranil—P.M.*

235 Jobst Institute
*Venous Pressure Gradient Supports*

234 Eli Lilly and Company
*Kefzol*

199-200 Mead Johnson Laboratories
*Quibron*
*Vasodilan*

183-184 Merck Sharp & Dohme
*Aldomet*

173 Roche Laboratories
Div. of Hoffman-LaRoche
*Librium*

Covers 3&4 Roche Laboratories
Div. of Hoffman-LaRoche
*Valium*

181 Upjohn Pharmaceuticals
*Tolinase*

248-249 Warren Teed Laboratories
*Kaon Elixir & Tabs*

185 Warren Teed Laboratories
*Modane*


## Insurance


242 Medical Protective Co.
*Professional Liability Ins.*

237 Parker Aleshire and Co.
*Group Insurance*


## Services and Continuing Education


177-178 Blue Cross/Blue Shield Report

232 Classified Advertising

229 Cook County Graduate School
*Continuing Medical Education*

192 Illinois Council for Continuing Medical Education
*Annual Congress*

191 Kidder Peabody & Co., Inc.
*Government National Mortgage Association Certificates*

187 Medical World News

240-241 Pharmaceutical Manufacturers Association
*Patient Package Inserts*

233 Ravenswood Hospital
*Director of Medical Education Wanted*

250 Rush Presbyterian-St. Luke's Medical Center
*Scoliosis School Screening Program*

233 Rush Presbyterian-St. Luke's Medical Center
*Health Education Programs*

229 South Carolina Medical Association
*Doctors Wanted*

231 Western Realty Company
*Water's Islands*

243 World Health Information Services, Inc.
*Telecast Symposium*

BALCONY


# Illinois Medical Journal

OFFICIAL JOURNAL OF THE
ILLINOIS STATE MEDICAL SOCIETY

Volume 153, No. 4, April, 1978


NEW YORK ACADEMY OF MEDICINE
LIBRARY
2 EAST 103RD STREET
NEW YORK, NEW YORK 10029

## The Illinois Experience with MECO

*...stribution of physicians in various specialties has been a concern of the public, politi... ...ucators and medical societies. It is frequently said that medical schools should be ... more general practitioners and fewer specialists, and that doctors should be encour... ...ettle in small communities that lack easy access to health care. This article reports on ... ...t to correct that problem. . . . 288*

## ...ger-Ellison Syndrome ... ...eatment with $H_2$ Receptor Antagonists

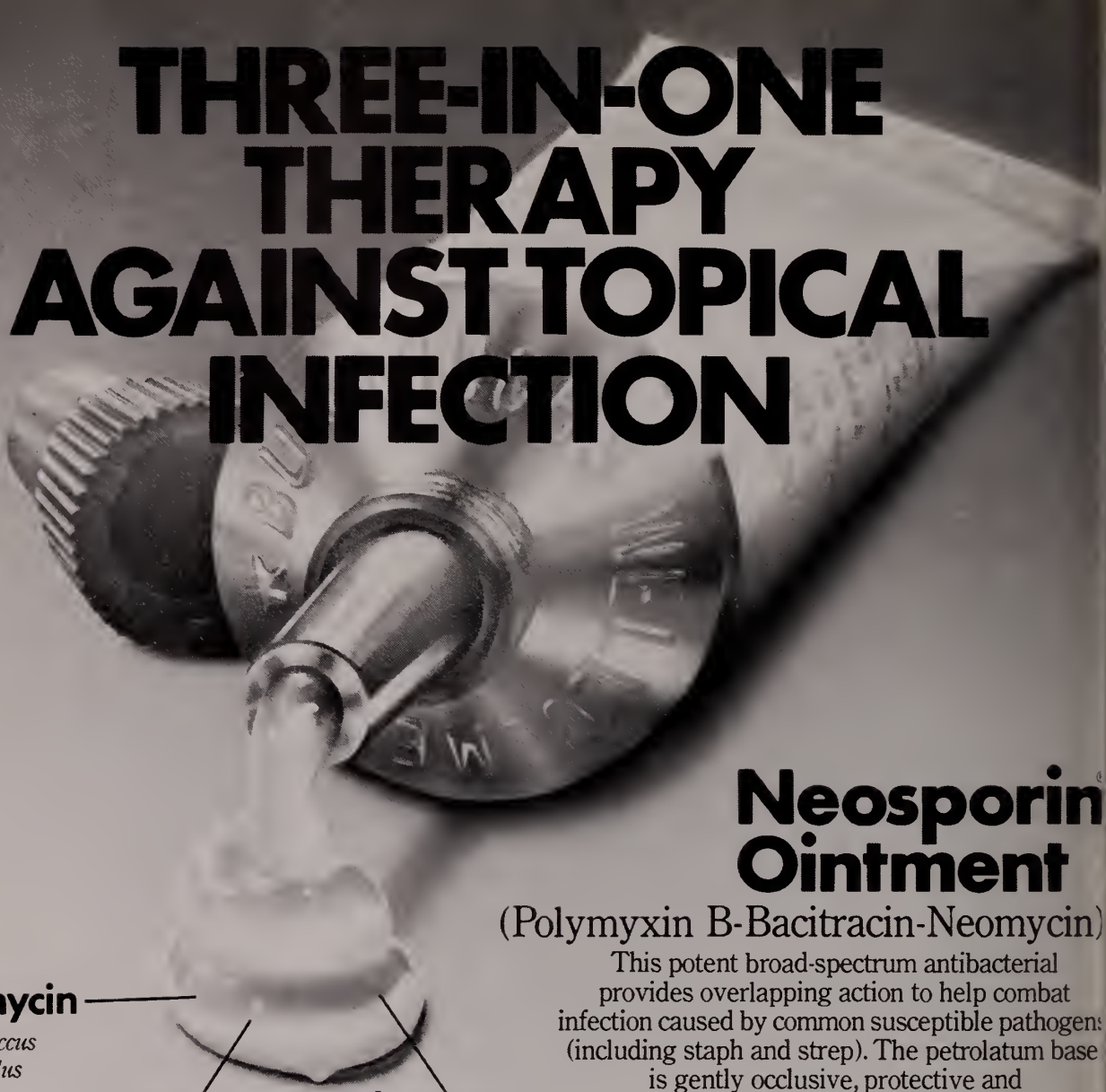
*...ts who have intractable ulcer disease secondary to hypersecretory states, such as Zollinger-Ellison Syndrome, are usually difficult to treat medically. It is often difficult to surgically remove all of the gastrin-secreting tumor. This article reports on a patient with Zollinger-Ellison Syndrome who is being treated with $H_2$ receptor antagonists rather than surgery. . . . 283*

## Immunopathologic Aspects of Renal Disease

*Correlation of experimental and clinical lesions through immunohistologic observations has increased our understanding of the etiology and pathophysiology of renal diseases to such a degree that such observations are now of practical value in diagnosis and management. Examination of renal biopsies with only five widely used and commercially available antisera may provide within hours a very good diagnostic clue. . . . 292*


...lent's Page . . . 331
... of Contents . . . 253

# THREE-IN-ONE THERAPY AGAINST TOPICAL INFECTION



## Neosporin® Ointment

(Polymyxin B-Bacitracin-Neomycin)

This potent broad-spectrum antibacterial provides overlapping action to help combat infection caused by common susceptible pathogens (including staph and strep). The petrolatum base is gently occlusive, protective and enhances spreading.

**Neomycin**
*Staphylococcus*
*Haemophilus*
*Klebsiella*
*Aerobacter*
*Escherichia*
*Proteus*
*Corynebacterium*
*Streptococcus*
*Pneumococcus*

**Bacitracin**
*Staphylococcus*
*Corynebacterium*
*Streptococcus*
*Pneumococcus*

**Polymyxin B**
*Pseudomonas*
*Haemophilus*
*Klebsiella*
*Aerobacter*
*Escherichia*

*In vitro* overlapping antibacterial action of Neosporin® Ointment (polymyxin B-bacitracin-neomycin).

Wellcome

**Burroughs Wellcome Co**
Research Triangle Park
North Carolina 27709

---

## Neosporin® Ointment

(Polymyxin B-Bacitracin-Neomycin)

Each gram contains: Aerosporin® brand Polymyxin B Sulfate 5,000 units; zinc bacitracin 400 units, neomycin sulfate 5 mg (equivalent to 3.5 mg neomycin base); special white petrolatum qs; in tubes of 1 oz and 1/2 oz and 1/32 oz (approx.) foil packets.

**WARNING:** Because of the potential hazard of nephrotoxicity and ototoxicity due to neomycin, care should be exercised when using this product in treating extensive burns, trophic ulceration and other extensive conditions where absorption of neomycin is possible. In burns where more than 20 percent of the body surface is affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended.

When using neomycin-containing products to control secondary infection in the chronic dermatoses, it should be borne in mind that the skin is more liable to become sensitized to many substances, including neomycin. The manifestation of sensitization to neomycin is usually a low grade reddening with swelling, dry scaling and itching; it may be manifest simply as failure to heal. During long-term use of neomycin-containing products, periodic examination for such signs is advisable and the patient should be told to discontinue the product if they are observed. These symptoms regress quickly on withdrawing the medication. Neomycin-containing applications should be avoided for that patient thereafter.

**PRECAUTIONS:** As with other antibacterial preparations, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

**ADVERSE REACTIONS:** Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section).

Complete literature available on request from Professional Services Dept. PML.

IMJ

Illinois Medical Journal

APRIL, 1978 Vol. 153, No. 4 CONTENTS

*Clinical Articles*

283 Zollinger-Ellison Syndrome: Treatment with Histamine $H_2$ Receptor Antagonists
*By John K. Siepler, Pharm.D., Philip Donahue, M.D., Keith Campagna, Pharm.D., and C. T. Bombeck, M.D./Chicago*

*Special Articles*

265 AMA Proposed Amendments to P.L. 93-641: The National Health Planning and Resources Development Act

278 A Matter of Principles: AMA Proposed New Principles of Medical Ethics

288 The Illinois Experience with MECO
*By David M. Roxe, M.D./Chicago*

*Professional Liability*

276 Actions for Civil Malpractice
*By Robert J. Folonie, LL.B./Chicago*

*Seminars in Immunopathology and Oncology*

292 *Richard J. Ablin, Ph.D., Contributing Editor*
Some Immunopathologic Aspects of Renal Disease
*By Elizabeth V. Potter, M.D./Chicago*

*Attacking the Cost Crisis*

298 Attacking the Cost Crisis
*By L. S. Doyle/Galesburg, Richard C. Shaw, M.D./Chicago and George Maroney/Carbondale*

*Surgical Grand Rounds*

305 Case Report: Iatrogenic Injury of the Brachial Artery
*John M. Beal, M.D., Contributing Editor*

*Rheumatology Rounds*

318 Extensor Tendon Rupture in a Rheumatoid Hand
*L. F. Layfer and J. V. Jones, Contributing Co-Editors*

*Pediatric Perplexities*

326 Mucocutaneous Lymph Node Syndrome
*Ruth Andrea Seeler, M.D., Contributing Editor*
*By Adisesha B. Reddy, M.D./Chicago*

*President's Page*

331 Time Well Spent
*David S. Fox, M.D.*

*(Contents continued on overleaf)*

## *Features*


255 Clinics for Crippled Children
258 EKG of the Month
261 Obituaries
264 Viewbox
270 Housestaff News
310 Pulse of the ISMS Auxiliary
312 Physician Recruitment
314 Illinois Society, American Association of Medical Assistants
316 ISMS Guide to Continuing Medical Education
322 Classified Advertising
329 Doctor's News


## *Staff*


**Managing Editor** — **Richard A. Ott**
**Assistant Editor** — **Mariann E. McGuire**
**Executive Administrator** — **Roger N. White**

*(Cover by Richard A. Ott)*

**PUBLICATIONS COMMITTEE**
Lawrence L. Hirsch, M.D., Chicago, *Chairman*
Kenneth A. Hurst, M.D., Naperville
Robert P. Johnson, M.D., Springfield
Alfred J. Kiessel, M.D., Decatur

**Editorial Board**
J. William Roddick, Jr., M.D., *Chairman*
Eli L. Borkon, M.D., Carbondale
Daniel R. Cunningham, M.D., Wilmette
Raymond A. Dieter, Jr., M.D., Glen Ellyn
James G. Ekeberg, M.D., Palatine
Ediz Z. Ezdinli, M.D., Kenilworth
Carl Neuhoff, M.D., Peoria
Constantine S. Soter, M.D., Arlington Heights
Donald D. VanFossan, M.D., Springfield

Contributor in Surgery: John M. Beal, M.D., Chicago
Contributor in Maternal Death Studies: Robert R. Hartman, M.D., Jacksonville
Contributor in Pediatric Perplexities: Ruth Andrea Seeler, M.D., Chicago
Contributor in Radiology: Leon Love, M.D., Maywood
Contributor in Cardiology: John R. Tobin, M.D., Maywood
Contributor in Immunopathology: Richard J. Ahlin, Ph.D., Chicago
Contributor in Rheumatology: L. F. Layfer, M.D., Chicago

**ILLINOIS STATE MEDICAL SOCIETY**

OFFICERS
David S. Fox, M.D., President
826 E. 61st St., Chicago 60637
P. John Seward, M.D., President-Elect
2400 N. Rockton, Rockford 61101
Herschel Browns, M.D., 1st Vice-President
4600 N. Ravenswood, Chicago 60640
G. W. Giehelhansen, M.D., 2nd Vice-President
1101 Main St., Peoria 61606
Audley F. Connor, Jr., M.D., Secretary-Treasurer
7531 S. Stony Island Ave., Chicago 60649

HOUSE OF DELEGATES
Cyril C. Wiggishoff, M.D., Speaker
25 E. Washington, Chicago 60602
Robert P. Johnson, M.D., Vice-Speaker
108 Maple Grove, Springfield 62707

TRUSTEES
1st District: 1980, John J. Ring, M.D.
511 Hawley, Mundelein 60060
2nd District: 1980, Allan L. Goslin, M.D.
712 N. Bloomington, Streator 61364
3rd District: 1979, Alfred Clementi, M.D.
675 W. Central Rd., Arlington Heights 60005
3rd District: 1980, Raymond J. Des Rosiers, M.D.
1044 N. Francisco, Chicago 60622
3rd District: 1979, Robert T. Fox, M.D.
2136 Robincrest, Glenview 60025
3rd District, 1979, Jere Freidheim, M.D.
3050 S. Wallace, Chicago 60616
3rd District: 1981, Morris T. Friedell, M.D.
7531 S. Stony Island Ave., Chicago 60649
3rd District: 1981, Henrietta Herbolsheimer, M.D.
5528 S. Hyde Park Blvd., Apt. 1202, Chicago 60637
3rd District: 1981, Lawrence L. Hirsch, M.D.
2434 Grace St., Chicago 60618
3rd District: 1980, Harold J. Lasky, M.D.
55 E. Washington, Chicago 60602
3rd District: 1980, Richard N. Rovner, M.D.
645 N. Michigan, Suite 920, Chicago 60611
3rd District: 1980, Joseph C. Sherrick, M.D.
303 E. Superior, Chicago 60611
4th District: 1979, Fred Z. White, M.D.
723 N. Second St., Chillicothe 61523
5th District: 1979, Paul F. Mahon, M.D.
326 N. Seventh St., Springfield 62702
6th District: 1981, Robert R. Hartman, M.D.
1515 A. W. Walnut, Jacksonville 62650
7th District: 1979, Alfred J. Kiessel, M.D.
1 Powers Lane Pl., Decatur 62522
8th District: 1979, James Laidlaw, M.D.
104 W. Clark, Champaign 61820
9th District: 1981, Warren D. Tuttle, M.D.
203 N. Vine St., Harrisburg 62946
10th District: 1981, Julian W. Buser, M.D.
6600 W. Main St., Belleville 62223
11th District: 1980, Kenneth A. Hurst, M.D.
52 Bunting Lane, Naperville 60540
12th District: 1980, Joseph Perez, M.D.
5670 E. State St., Rockford 61108
Trustee-At-Large: George T. Wilkins, M.D.
3165 Myrtle, Granite City 62040
Chairman of the Board: Robert R. Hartman, M.D.
1515 A. W. Walnut, Jacksonville 62650



Microfilm copies of current as well as some back issues of the *Illinois Medical Journal* may be purchased from Xerox University Microfilm, 300 North Zeeb Road, Ann Arbor, Mich. 48106.

Contents of *IMJ* are listed in the *Current Contents/Clinical Practice.*

Published by the Illinois State Medical Society, 55 E. Monroe St., Chicago, Ill. 60603 (312-782-1654)


Copyright, 1978. The Illinois State Medical Society. All material subject to this copyright may be photocopied for the noncommercial purpose of scientific or educational advancement.


Subscription $8.00 per year, in advance, postage prepaid, for the United States, Cuba, Puerto Rico, Philippine Islands and Mexico. $10.00 per year for all foreign countries included in the Universal Postal Union. Canada $8.50. U.S. Single current copies available at $1.00 ($1.10 by mail), back issues $1.50.

Second class postage paid at Chicago, Ill. When moving please notify Journal office of new address including old mailing label with notification, if possible. POSTMASTER: Send notice on form No. 3579 to Illinois State Medical Society, 55 E. Monroe St., Chicago, Ill. 60603.

Pharmaceutical advertising must be approved by the ISMS Publications Committee. Other advertising accepted after review by Publications Committee or Board of Trustees. All copy or plates must reach the Journal office by the fifteenth of the month preceding publication. Rates furnished upon request.

Original articles will be considered for publication with the understanding that they are contributed only to the *Illinois Medical Journal.* The ISMS denies responsibility for opinions and statements expressed by authors or in excerpts, other than editorial or allied views or statements which reflect the authoritative action of the ISMS or of reports on official actions, policies or positions. Views expressed by authors do not necessarily represent those of the Society; any connection with official policies is coincidental.

The *Illinois Medical Journal* is published by the Illinois State Medical Society as an educational and professional informational magazine and distributed as a benefit of membership in the Illinois State Medical Society. Its intent is to keep members current in medical knowledge and is a part of a continuing medical education program. Socioeconomic matters, affecting as they do a changing pattern in the proper delivery of medical care, are considered an inherent element in medical education.

# Clinics for Crippled Children Listed for May

Thirty-four clinics for Illinois' physically handicapped children have been scheduled for May hy the University of Illinois, Division of Services for Crippled Children. The Division will count twenty-three general clinics providing diagnostic orthopedic, pediatric, speech and hearing examination, along with medical social and nursing services. There will be nine special clinics for children with cardiac conditions and two for children with cerebral palsy. Any private physician may refer to or bring to a convenient clinic any child or children for whom he may want examination or consultative services.

May 2 Park Ridge Cardiac—Lutheran General Hospital
May 3 Mt. Vernon—Good Samaritan Hospital
May 3 Hinsdale—Hinsdale Sanitarium
May 4 Effingham—St. Anthony Memorial Hospital
May 4 Pittsfield—Illini Community Hospital
May 4 Sterling—Sterling Community Hospital
May 4 Lake County Cardiac—Victory Memorial Hospital
May 5 Division Cardiac. U. of I. at the Medical Center
May 8 Peoria Cardiac—St. Francis Hospital
May 9 Peoria—St. Francis Hospital
May 9 East St. Louis—Christian Welfare Hospital
May 10 Champaign-Urbana—McKinley Hospital
May 10 Joliet—St. Joseph's Hospital
May 10 Chicago Heights General—St. James Hospital
May 11 Springfield—St. John's Hospital
May 11 Macomb—McDonough District Hospital
May 12 Chicago Heights Cardiac—St. James Hospital
May 15 Maywood—Loyola Medical Center
May 16 Anna—Union County Hospital
May 16 Rock Island—Moline Public Hospital
May 16 Decatur—Decatur Memorial Hospital
May 16 Belleville—St. Elizabeth's Hospital
May 17 Centralia—St. Mary's Hospital
May 17 Springfield Ped-Neuro—St. John's Hospital
May 17 Evergreen Park—Little Company of Mary Hospital
May 18 Rockford—Rockford Memorial Hospital
May 18 Elmhurst Cardiac—Memorial Hospital of DuPage County
May 19 Kankakee Cardiac—St. Mary's Hospital
May 22 Peoria Cardiac—St. Francis Hospital
May 23 Peoria—St. Francis Hospital
May 24 Rock Island Cerebral Palsy—Foundation for Crippled Children and Adults
May 24 Chicago Heights General—St. James Hospital
May 24 Elgin—Sherman Hospital
May 26 Chicago Heights Cardiac—St. James Hospital

The Division of Services for Crippled Children is the official state agency established to provide medical, surgical, corrective and other services and facilities for diagnosis, hospitalization and after-care for children with crippling conditions or who are suffering from conditions that may lead to crippling. In carrying on its program, the Division works cooperatively with local medical societies, hospitals, the Illinois Children's Hospital-School, civic and fraternal clubs, visiting nurse association, local social and welfare agencies, local chapters of the National Foundation and other interested groups. In all cases, the work of the Division is intended to extend and supplement, not supplant, activities of other agencies, either public or private, state or local, carried on in behalf of crippled children.



**Librax®**
Each capsule contains 5 mg chlordiazepoxide HCl and 2.5 mg clidinium Br.

**Please consult complete prescribing information, a summary of which follows:**

**Indications:** Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

"Possibly" effective: as adjunctive therapy in the treatment of peptic ulcer and in the treatment of the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis

Final classification of the less-than-effective indications requires further investigation

**Contraindications:** Glaucoma, prostatic hypertrophy, benign bladder neck obstruction, hypersensitivity to chlordiazepoxide HCl and/or clidinium Br.

**Warnings:** Caution patients about possible combined effects with alcohol and other CNS depressants, and against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Physical and psychological dependence rarely reported on recommended doses, but use caution in administering Librium® (chlordiazepoxide HCl) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions) reported following discontinuation of the drug.

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy. Advise patients to discuss therapy if they intend to or do become pregnant.**

As with all anticholinergics, inhibition of lactation may occur.

**Precautions:** In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially, increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship not established.

**Adverse Reactions:** No side effects or manifestations not seen with either compound alone reported with Librax. When chlordiazepoxide HCl is used alone, drowsiness, ataxia, confusion may occur, especially in elderly and debilitated, avoidable in most cases by proper dosage adjustment, but also occasionally observed at lower dosage ranges. Syncope reported in a few instances. Also encountered: isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent, generally controlled with dosage reduction; changes in EEG patterns may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice, hepatic dysfunction reported occasionally with chlordiazepoxide HCl, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax typical of anticholinergic agents, i.e., dryness of mouth, blurring of vision, urinary hesitancy, constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.

ROCHE
Roche Products Inc.
Manati, Puerto Rico 00701



## Anxiety...
## Often a significant feature of irritable bowel syndrome*

## The action of Librium®
## (chlordiazepoxide HCl)

## A significant advantage of adjunctive

# Librax®

Each capsule contains
5 mg chlordiazepoxide HCl and
2.5 mg clidinium Br.

## Antianxiety
## Antisecretory
## Antispasmodic

Librax is unique among G.I. medications in providing the specific antianxiety action of Librium® (chlordiazepoxide HCl) as well as the potent antisecretory and antispasmodic actions of Quarzan® (clidinium Br) for adjunctive therapy of irritable bowel syndrome* and duodenal ulcer.*

*Librax has been evaluated as possibly effective for this indication.
Please see brief summary of prescribing information on preceding page.

ROCHE

# Time is the test of all things.



BRIEF SUMMARY

**Indications**: Oral potassium therapy for the prevention and treatment of hypokalemia which may occur secondary to diuretic or corticosteroid administration. May be used in the treatment of cardiac arrhythmias due to digitalis intoxication.

**Contraindications**: Severe renal impairment with oliguria or azotemia, untreated Addison's disease, adynamia episodica hereditaria, acute dehydration, heat cramps and hyperkalemia from any cause.

**Precautions:** Potassium intoxication by oral administration rarely occurs in patients with normal kidney function, however, potassium supplements must be administered with caution, since the amount of the deficiency or daily dosage is not accurately known. Frequent checks of the clinical status of the patient, and periodic ECG and/or serum potassium levels should be made. High serum concentrations of potassium ion may cause death through cardiac depression, arrhythmias or arrest. This drug should be used with caution in the presence of cardiac disease.

In hypokalemic states, especially in patients on a low-salt diet, hypochloremic alkalosis is a possibility that may require chloride as well as potassium supplementation.

**Adverse Reactions:** Nausea, vomiting, diarrhea, and abdominal discomfort have been reported. The most severe adverse effect is hyperkalemia.

**Overdosage:** Potassium intoxication may result from overdosage of potassium or from therapeutic dosage in conditions stated under "Contraindications". Hyperkalemia, when detected, must be treated immediately because lethal levels can be reached in a few hours.

# Kaon® Elixir

potassium gluconate)

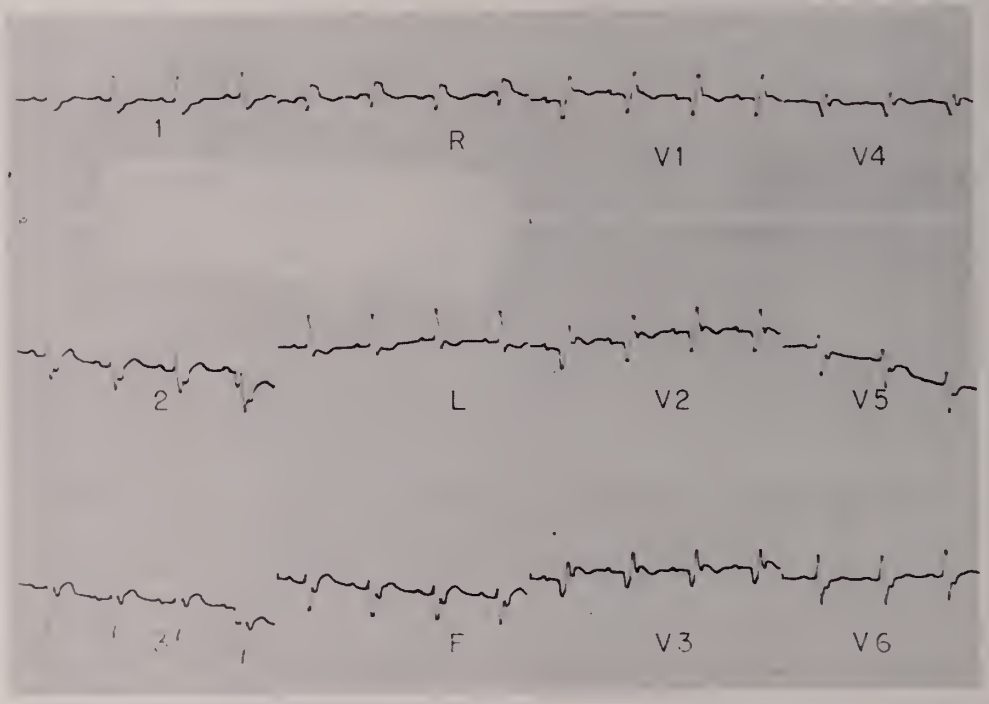
20 mEq per 15 ml

**WARREN-TEED**
LABORATORIES, INC.
DIVISION OF **ADRIA LABORATORIES INC.**
COLUMBUS, OHIO 43215

# ekg of the month

John F. Moran, M.S., M.D., David L. Fishman, M.D.,
Patrick J. Scanlon, M.D., Sarah A. Johnson, M.D.,
John R. Tobin, M.S., M.D., and Rolf M. Gunnar, M.S., M.D.
Section of Cardiology, Department of Medicine,
Loyola University Stritch School of Medicine

This is a sixty-three-year-old lady who was brought to the emergency room because of severe breathlessness. She described a non-specific chest discomfort on the day before and the morning of her visit to this emergency service. Initial physical examination demonstrated peripheral cyanosis, bilateral crepitant rales to mid-scapulae, an active precordium, and a loud gallop rhythm on exam of the heart. A chest X-ray demonstrated cardiomegaly and acute pulmonary edema. After treatment, she began to feel more comfortable. This 12 lead ECG was then obtained.




## *Questions:*

**1. The ECG shows:**

A. An acute anteroseptal wall myocardial infarction.
B. Complete right bundle branch block.
C. Left axis deviation.
D. A current of injury—ST segment elevation.
E. All of the above.

**2. The treatment given here included:**

A. Bedrest. Oxygen therapy.
B. Digitalis.
C. Diuretic therapy.
D. All of the above.

*(Continued on page 320)*

Blue Cross®
Blue Shield®

REPORT
FOR *Illinois Physicians*

## Approval of Free Standing Ambulatory Surgical Facilities

Since 1974 and the enactment of enabling legislation, Blue Cross and Blue Shield has been a proponent of Free-Standing Ambulatory Surgical Facilities as a further means of controlling health care costs without sacrificing patient needs.

Five facilities have been approved for Plan affiliation and are now in operation. They include: Northwest Surgicare, Arlington Heights; Hugar Surgery Center, Elmwood Park; Forest Hills Surgical Center, Justice; Hinsdale Surgical Center, Hinsdale and Notre Dame Hills in Belleville, Illinois. We also are negotiating with three other facilities.

Prior to the enactment of the legislation Blue Cross' policy was that surgical care of ambulatory patients should take place within licensed hospitals, and that hospitals should make special arrangements to facilitate care of ambulatory patients.

When hospitals began to expand their surgical programs to include procedures that could safely be performed on an ambulatory basis, Blue Cross encouraged the development of the programs.

Each new free-standing facility which has been approved has a contract with the Plan that includes a Procedure List and Charge Schedule for surgery and operating room services, necessary tests and x-rays.

The professional services of radiologists, pathologists and anesthesiologists are billed separately to patients aside from contracts.

Blue Cross members having surgery performed at any of these facilities are eligible to receive outpatient surgical benefits in accordance with provisions of their Blue Cross health care programs.

A Free-Standing Ambulatory Surgical Facility wishing to affiliate with the Plan is required to comply with certain minimum standards contained in a formal policy. Some of the highlights of the policy include:

1) Approval by an appropriate health planning agency.

2) The facility must be licensed by the state.

3) At such time as standards are developed for accreditation of facilities by the Joint Commission on Accreditation of Hospitals, the facility will have to be accredited.

4) It must have an organized Medical staff. The staff should have bylaws which cover such matters as admission of physicians to the staff; extent of surgical procedures; content and form of medical records and review of clinical work.

5) The facility should include an operating room, recovery room and an adequate clinical laboratory. Complete radiology, clinical laboratory and other services need not be included but must be available through a formal arrangement between the facility and hospital or free-standing clinic recognized by the Plan.

6) It must have emergency equipment available to handle emergencies that may arise in the course of treatment of its own patients.

7) It must have a governing authority with legal and moral responsibility to operate it.

8) The governing authority and Medical staff must have developed and adopted a statement of the specific surgical procedures which will be performed.

9) Patients treated should be admitted by authority of a member of the Medical staff, and care should remain under supervision of the admitting physician or transferred to another member of the Medical staff.

Adequate medical records must be maintained for each patient containing at least the following: Admitting diagnosis; report of medical history and physical examination; laboratory test results; x-ray reports; operative reports; anesthesia records; pathology specimen examination reports; medication ordered and given; and discharge summary.

Operating policy should be such that no patient shall be subject to surgical treatment until the patient's medical record contains at least a medical history, report of physical examination and appropriate tests, except in an emergency.

10) An active utilization review program should be established and documented. In addition, the staff should have a functioning Tissue Committee.

11) There must be an adequate employee staff including registered professional nursing personnel. At least one physician should be on the premises at all times when patients are under care. Anesthesia service should be performed by a qualified anesthesiologist or certified nurse anesthetist under his direct supervision.

12) A written agreement should exist with one or more general hospitals affiliated with the Plan that are within reasonable distance of the facility to provide prompt transfer of patients requiring hospital care. The hospital should agree to provide emergency and inpatient care under supervision of a member of its Medical staff. Complete patient information should be transmitted with the patient at the time of transfer. The hospital, as a party to the agreement, should have the right to review all care rendered in the facility.

13) Payment of services rendered to Blue Cross members must be subject to the same cost reconciliation or prospective rate formulas and other controls which apply to hospital services and be documented in the contract between the Plan and the facility.

(Further information on approval standards for Free-Standing Ambulatory Surgical Facilities is available upon request, from Mr. Harold Staidl, Vice President, Provider Affairs, Health Care Service Corporation, 233 N. Michigan Avenue, Chicago, Illinois 60601).

## BILLING FOR REFRACTIVE PROCEDURES

Refractive procedures of the eye are excluded from coverage and consequently not reimbursable by the Medicare program. Although a refraction is a separate and distinct procedure, physicians have seldom routinely identified and separately charged patients for this procedure. Generally, the practice has been for the physician to make a single inclusive charge, either for an initial diagnostic examination or a follow-up visit for further diagnosis and treatment. This charge covered the physician's charges for all the procedures performed, including any procedures that may have been performed to determine the refractive state of the eyes.

In November, 1975, instructions were received from the Bureau of Health Insurance which stated that whether the physician makes a single inclusive charge, or makes a separate charge for refractive services, **the charge for the refractive services should be excluded before a reasonable charge determination for an eye examination can be made.**

If the bill for the eye examination shows a separate charge for the refraction, and other separate charges for the covered eye services, the carrier can easily determine the reasonable charge. When a single inclusive charge is made for an eye examination, certain guidelines must be followed to determine the charge for the refractive services.

In a comprehensive ophthalmological examination or an initial eye examination, which may include refractive procedures, the value of the procedures performed to determine the refractive state of the eyes may generally be expected to be about 20% of the charge submitted by the physician.

For example, if the submitted charge for an initial eye examination is $30.00, the following calculations would be made:

$30.00 multiplied by 20% = $6.00
The Charge for the refraction is then $6.00.
$30.00 minus $6.00 = $24.00
The submitted charge for the initial eye examination is then $24.00

The Explanation of Medicare Benefits would show the "amount billed" or the "total charges" on two separate lines; the "amount billed" or the "total charges" for the initial eye examination as $24.00 and the "amount billed" or "total charges" for the refraction as $6.00. This $6.00 would be denied as non-covered services.

In a follow-up examination where refractive procedures are performed, the value of the refractive procedures, as a percent of the total charges made by the physician, is generally higher. Although professional estimates vary, the most common view is that the refractive procedures represent approximately 33⅓% of the total submitted charge for a follow-up examination. For example, if the submitted charge for a follow-up examination is $15.00, the following calculations would be made:

$15.00 multiplied by 33⅓% (.333) = $5.00
(rounded off to the nearest .05)
The charge for the refraction is then $5.00.
$15.00 minus $5.00 = $10.00.
The submitted charge for the follow-up eye examination is then $10.00.

The Explanation of Medicare Benefits would show $10.00 as the "amount billed" or "total charge" for the refraction. The $5.00 refraction charge would be denied.

Office visits for post-operative follow-up care must also state whether or not a refractive procedure was performed.

According to instructions from the Bureau of Health Insurance, the carrier should assume that a comprehensive ophthalomological examination or consultation, in the hospital or office, includes refractive services, and should deduct the appropriate amount unless the physician has specified "no refraction."

**Physicians are urged to separate their charge for refractive procedures themselves. Whenever an initial eye examination, a follow-up visit, or a consultation does not include a refractive procedure, this should be clearly stated on the bill or claim.**

For example:
Initial eye examination—$30.00
NO REFRACTION

When this information is present, the Medicare carrier will not reduce the charge. In the absence of this information, the carrier must presume that an eye refraction was included in the examination and reduce the charge accordingly.

**Physicians should keep in mind that failure to specify "no refraction" or failure to break down the charge will affect their customary charge profile.**

## Changes in Laboratory Participation

Notice was received from the Bureau of Health Insurance office of the Social Security Administration, that the following changes are effective in program participation of these laboratories:

**Opening Approved:**
Unity Clinical Laboratory, Inc.
4801 West Montrose Avenue
Chicago, Illinois 60641
Provider Number: 14-8347
Effective Date: October 4, 1977

**Closings:**
A-J Cytolab
5920 Warren Court
Morton Grove, Illinois 60053
Provider Number: 14-8341
Effective Date: January 30, 1978

## *Obituaries*

°Anderson, Robert K., Oak Park, died February 15 at the age of 63. Doctor Anderson was a 1941 graduate of Northwestern Medical School.

°°Greene, Earle I., Chicago, died February 15 at the age of 79. Doctor Greene was a 1923 graduate of Rush Medical College.

°°Grogan, Edward B., Galesburg, died January 29 at the age of 87. Doctor Grogan was a 1922 graduate of Wayne State University Medical College.

°Hoppins, Arthur W., Joliet, died December 14 at the age of 71. Doctor Hoppins was a 1931 medical school graduate from Ontario, Canada.

°Kamenear, Harold R., Chicago, died February 13 at the age of 57. Doctor Kamenear was a 1945 graduate of the University of Illinois School of Medicine.

°°Krasso, Hugo, Chicago, died February 22 at the age of 83. Doctor Krasso was a 1920 medical school graduate from Wien, Germany.

°Lackey, John T., Villa Park, died February 8 at the age of 45. Doctor Lackey was a 1964 medical school graduate from Indiana.

°Lieberstein, Joseph H., Oak Lawn, died March 6 at the age of 66. Doctor Lieberstein was a 1938 graduate of the Chicago Medical School.

°Lowell, William, Belvidere, died January 10 at the age of 35. Doctor Lowell was a 1965 graduate of the University of Illinois School of Medicine.

°O'Neill, Clement P., Rock Island, died February 18 at the age of 74. Doctor O'Neill was a 1929 graduate of the University of Illinois School of Medicine.

°Saft, James H., Chicago, died February 23 at the age of 51. Doctor Saft was a 1949 Tulane graduate.

°Steinberg, Harold H., Glencoe, died March 3 at the age of 65. Doctor Steinberg was a 1937 graduate of the University of Illinois School of Medicine.

°Taylor, Alan Mack, Danville, died March 9 at the age of 52. Doctor Taylor was a 1949 graduate of the University of Illinois. Doctor Taylor was Vice President-Elect and a former Secretary of the Vermilion County Medical Society.

°°Turley, Vigo Thomas, Decatur, died February 2 at the age of 84. Doctor Turley was a 1918 graduate of Hehnemann Medical College.

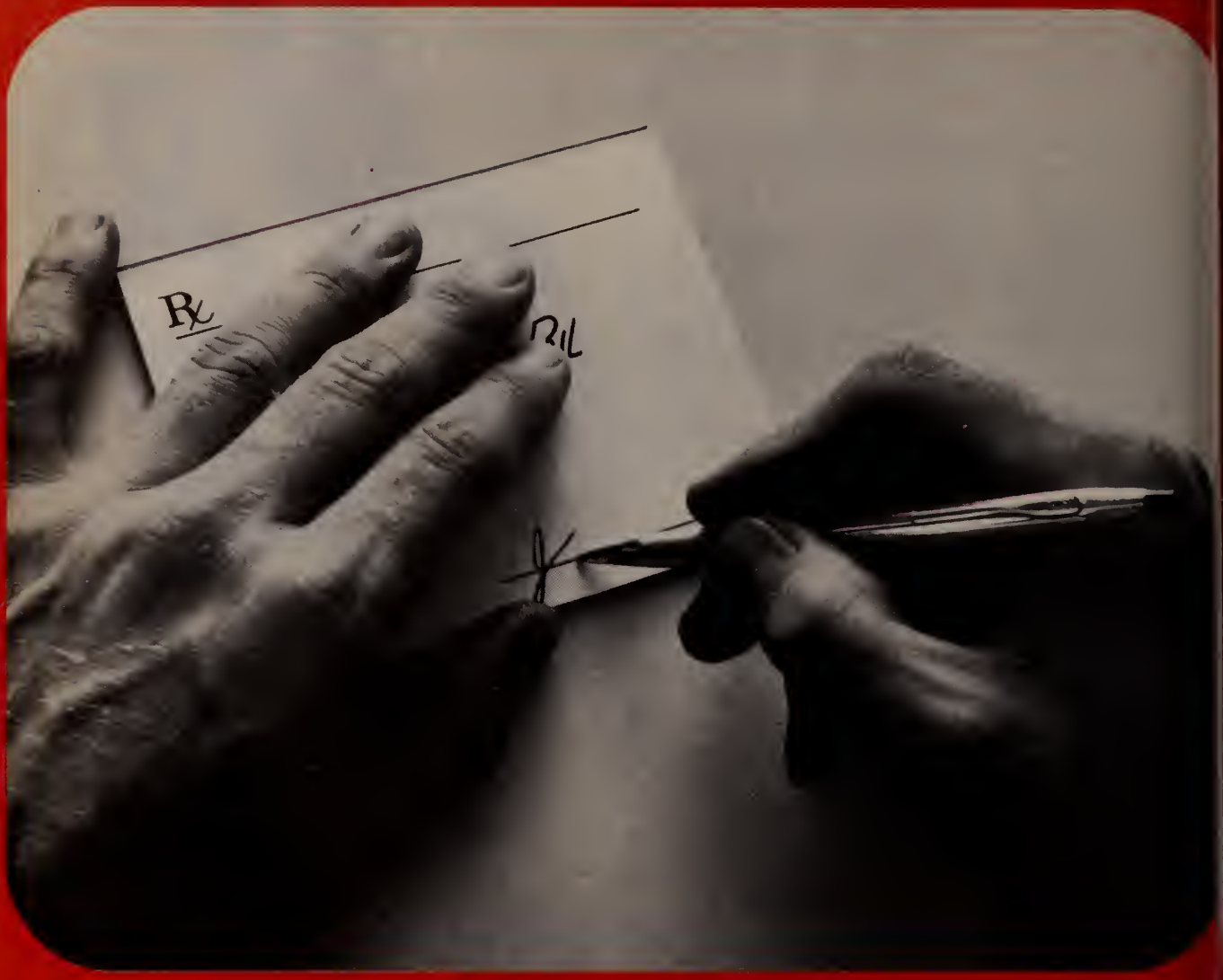
°Zayas, Agenor M., Lake Forest, died December 24 at the age of 56. Doctor Zayas was a 1949 graduate of the University of London.

*°Indicates ISMS member.*
*°°Indicates member of the ISMS Fifty Year Club.*



Modane®
(danthron)
LAXATIVE TABLETS
one tablet usually brings
gentle, overnight relief
WARREN-TEED
LABORATORIES, INC.
DIVISION OF AORIA LABORATORIES INC.
COLUMBUS, OHIO 43215

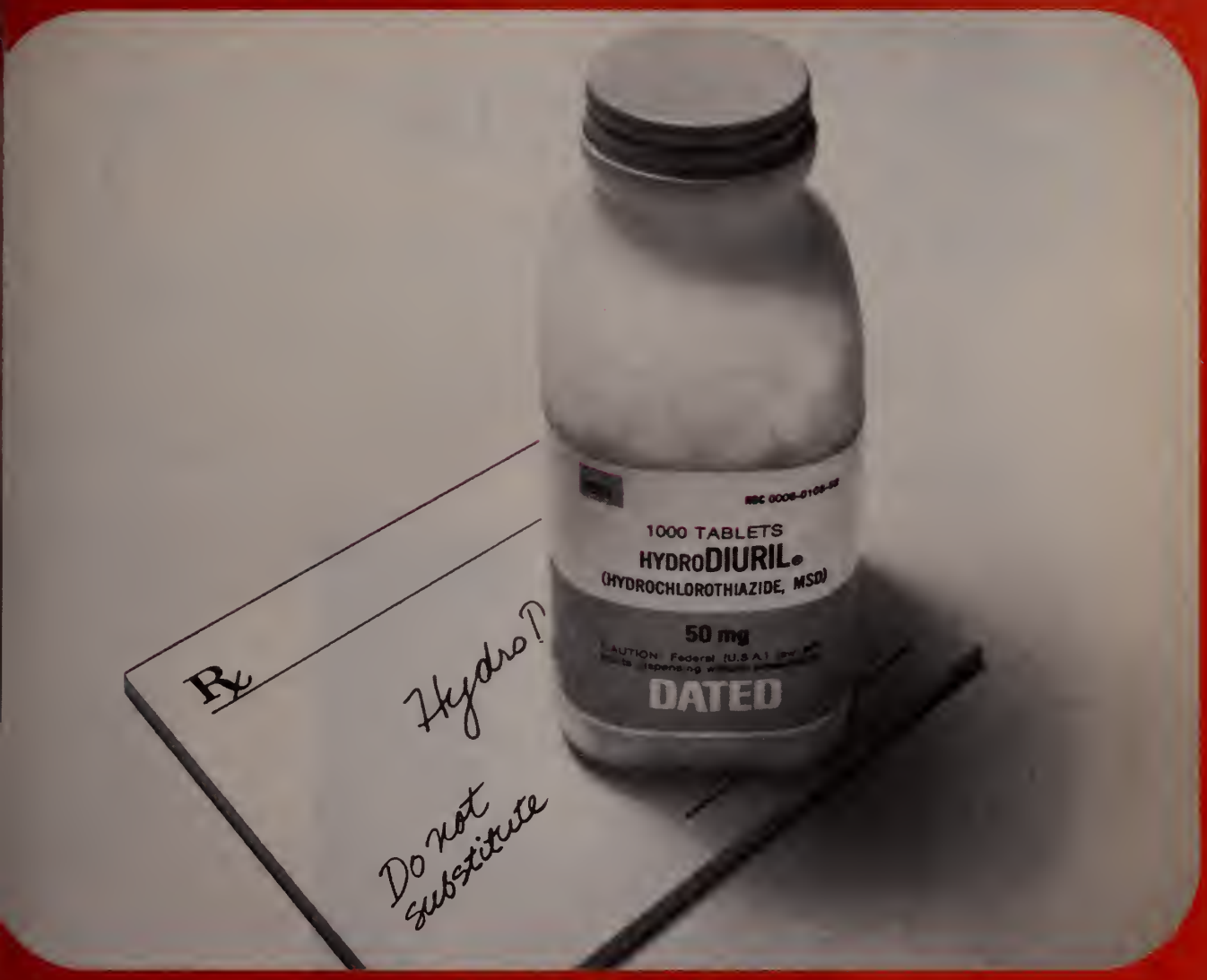
# There is no substitute




# yours...

**Contraindications:** Anuria; hypersensitivity to this or other sulfonamide-derived drugs.
**Warnings:** Use with caution in severe renal disease. In patients with renal disease, thiazides may precipitate azotemia. Cumulative effects may develop in patients with impaired renal function. Use with caution in patients with impaired hepatic function or progressive liver disease, since minor alterations of fluid and electrolyte balance may precipitate hepatic coma. May add to or potentiate action of other antihypertensive drugs; potentiation occurs with ganglionic or peripheral adrenergic blocking drugs. Sensitivity reactions may occur in patients with or without a history of allergy or bronchial asthma. Possibility of exacerbation or activation of systemic lupus erythematosus has been reported. Lithium generally should not be given with diuretics because they reduce its renal clearance and add a high risk of lithium toxicity. Read circulars for lithium preparations before use of such concomitant therapy. *Use in Pregnancy:* Thiazides cross placental barrier and appear in cord blood; in pregnancy, weigh anticipated benefit against possible hazards to fetus, including fetal or neonatal jaundice, thrombocytopenia, and possibly other adverse reactions that have occurred in adults. *Nursing Mothers:* Thiazides appear in breast milk; if use of drug is deemed essential, patient should stop nursing.
**Precautions:** Perform periodic determination of serum electrolytes to detect possible electrolyte imbalance. Observe all patients for clinical signs of fluid or electrolyte imbalance, namely, hyponatremia, hypochloremic alkalosis, and hypokalemia. Serum and urine electrolyte determinations are particularly important when patient is vomiting excessively or receiving parenteral fluids. Medication such as digitalis may also influence serum electrolytes. Warning signs, irrespective of cause, are dryness of mouth, thirst, weakness, lethargy, drowsiness, restlessness, muscle pains or cramps, muscular fatigue, hypotension, oliguria, tachycardia, and gastrointestinal disturbances such as nausea and vomiting. Hypokalemia may develop, especially with brisk diuresis in severe cirrhosis, with concomitant corticosteroid or ACTH therapy, or with inadequate oral electrolyte intake. Hypokalemia can sensitize or exaggerate response of heart to toxic effects of digitalis (e.g., increased ventricular irritability). Hypokalemia may be avoided or treated by use of potassium supplements, such as foods with a high potassium content. Any chloride deficit is generally mild and usually does not require specific treatment except under extraordinary circumstances (as in liver disease or renal disease). Dilutional hyponatremia may occur in edematous patients in hot weather; appropriate therapy is water restriction, rather than administration of salt except in rare instances when the hyponatremia is life threatening. In actual salt depletion, appropriate replacement is the therapy of choice.
Hyperuricemia may occur or frank gout may be precipitated in certain patients. Insulin requirements in diabetic patients may be increased, decreased, or unchanged; latent diabetes mellitus may become manifest. Thiazides may increase responsiveness to tubocurarine. Antihypertensive effects of the drug may be enhanced in post-sympathectomy patients. May decrease arterial responsiveness to norepinephrine; this diminution is not sufficient to preclude effectiveness of the pressor agent for therapeutic use. If progressive renal im-

# for experience—




# or ours.

airment becomes evident, consider withholding or discontinuing uretic therapy. Thiazides may decrease serum PBI levels without gns of thyroid disturbance. Calcium excretion is decreased by iazides. Pathologic changes in the parathyroid gland with hyper-alcemia and hypophosphatemia have been observed in a few patients n prolonged therapy; thiazides should be discontinued before testing r parathyroid function.

**dverse Reactions:** *Gastrointestinal System*—Anorexia; gastric ir-ation; nausea; vomiting; cramping; diarrhea; constipation; jaundice ntrahepatic cholestatic jaundice); pancreatitis; sialadenitis. *entral Nervous System*—Dizziness; vertigo; paresthesias; headache; anthopsia. *ematologic*—Leukopenia; agranulocytosis; thrombocytopenia; plastic anemia. *ardiovascular*—Orthostatic hypotension (may be aggravated by cohol, barbiturates, or narcotics). *ypersensitivity*—Purpura; photosensitivity; rash; urticaria; necrotizing ngiitis (vasculitis) (cutaneous vasculitis); fever; respiratory distress cluding pneumonitis; anaphylactic reactions. *ther*—Hyperglycemia; glycosuria; hyperuricemia; muscle spasm; eakness; restlessness; transient blurred vision. Whenever adverse reactions are moderate or severe, thiazide dosage hould be reduced or therapy withdrawn.

**lote:** When used with other antihypertensive drugs, careful observa-ons for changes in blood pressure must be made, especially during itial therapy. Dosage of other antihypertensive agents must be reduced by at least 50 percent as soon as this drug is added to the regimen. As blood pressure falls under the potentiating effect of this agent, further reduction in dosage, or even discontinuation, of other antihypertensive drugs may be necessary.

**How Supplied:** Tablets containing 25 mg hydrochlorothiazide each in bottles of 100 and 1000 and single-unit packages of 100; Tablets containing 50 mg hydrochlorothiazide each in bottles of 100, 1000, and 5000 and single-unit packages of 100; Tablets containing 100 mg hydrochlorothiazide each in bottles of 100.

*For more detailed information, consult your MSD representative or see full prescribing information. Merck Sharp & Dohme, Division of Merck & Co., Inc., West Point, Pa. 19486*

J6HD04(528)

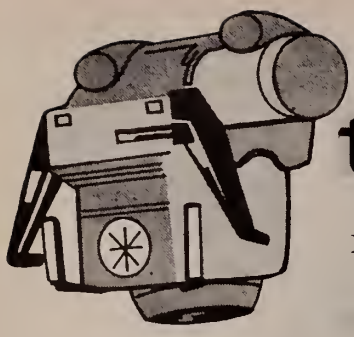
MSD
MERCK SHARP & DOHME

In hypertension

TABLETS 25 mg, 50 mg, and 100 mg

**HydroDIURIL®**

(HYDROCHLOROTHIAZIDE|MSD)



# the viewbox

Leon Love, M.D./Chairman/Department of Radiology
Loyola University Stritch School of Medicine

This Month's Viewbox was submitted by Richard A. Cooper, M.D.,
Assistant Professor of Radiology, Department of Radiology,
Loyola University Medical Center

The patient is a 20-year-old female who complains of right lower quadrant pain and nausea of two days duration.



**Figure 1**

## *What's your diagnosis?*

1. Perforated uterus
2. Appendicitis
3. Large Bowel Obstruction
4. Tubo-ovarian Abscess

*(Continued on page 335)*

# AMA Proposed Amendments to P.L. 93-641 The National Health Planning and Resources Development Act

*Pertinent features of amendments to the National Health Planning and Resources Development Act from the American Medical Association are excerpted below for membership information. The full text of the proposed amendments and comments is available from the American Medical Association, 535 N. Dearborn St., Chicago 60610.*

**Abbreviations**

HSA—Health Systems Agency
SHCC—State Health Coordinating Council
SHPDA—State Health Planning and Development Agency
CON—Certificate of Need

**A. Issuance of National Health Planning Guidelines**

Amendments 1, 2 and 3 are designed to demonstrate that any national guidelines issued by the Secretary of HEW are not to be mandatory standards. Guidelines would be advisory only and HSAs would have flexibility in the design of their local plans.

Amendment 4 would require consultation with certain professional parties before issuing any guidelines rather than allowing interpretation by the Secretary as to when consultation would occur.

**B. Definition of Provider and Health Care Facility**

The current definition of "provider of health care" would be amended. The term "indirect provider" would be removed. Thus only "direct" providers would be considered as providers.

The definition of health care facility would also be amended specifically to exclude a physician's office. The proposed amendment reads, in part:

*Section 1531(3) is amended to read as follows: "(3) The term 'provider of health care' means an individual who is a direct provider of health care (including a physician, dentist, osteopath or other health professional) in that the individual's primary current activity is the provision of health care to individuals or the administration of facilities or institutions (including hospitals, long-term care facilities, outpatient facilities, and health maintenance organizations) in which such care is provided and, when required by state law, the individual has received professional training in the provision of such care or in such administration and is licensed or certified for such provision or administration."*

**C. Representation of Physicians on Planning Bodies**

These amendments would establish a required representation for practicing physicians on the National Council for Health Planning and Development, (at least 4) on State Health Coordinating Council (SHCCs) and on HSA governing bodies (at least 50% of the providers on each body).

Another amendment would reduce consumer representation on the HSA from a majority to 40%. This amendment would be of particular significance if the present definition of "indirect provider" is not removed from the law as many indirect providers are not as representative as consumers.

*(Continued on page 267)*

# Angina freedom fighter...



Freedom from anginal pain



Freedom from anginal fear

1. Taken sublingually, Cardilate® (erythrityl tetranitrate) begins to work within 5 minutes, eliminating or reducing frequency and severity of anginal pain for up to two hours.
2. Fear of pain, a major deterrent to achieving acceptable (and desirable) levels of activity, including sex, may be allayed with Cardilate. Effective prophylaxis and improved exercise tolerance help toward normalizing the lives of anginal patients.

# Cardilate®
## (erythrityl tetranitrate)

**ilate® (erythrityl tetranitrate)**
CATIONS: For the prophylaxis and long-term treat-
of patients with frequent or recurrent anginal pain
reduced exercise tolerance associated with angina
ris, rather than for the treatment of the acute attack
gina pectoris, since its onset is somewhat slower
that of nitroglycerin.
CAUTIONS: As with other effective nitrites, some fall
od pressure may occur with large doses.
ion should be observed in administering the drug to
nts with a history of recent cerebral hemorrhage,
use of the vasodilation which occurs in the area
ugh therapy permits more normal activity, the
nt should not be allowed to misinterpret freedom
anginal attacks as a signal to drop all restrictions.
EFFECTS: No serious side effects have been
rted. In sublingual therapy, a tingling sensation (like
of nitroglycerin) may sometimes be noted at the
of tablet contact with the mucous membrane. If
ctionable, this may be mitigated by placing the tablet
e buccal pouch. As with nitroglycerin or other effec-
nitrites, temporary vascular headache may occur
g the first few days of therapy. This can be con-
d by temporary dosage reduction in order to allow
stments of the cerebral hemodynamics to the initial
ed cerebral vasodilation. These headaches usually
pear within one week of continuous therapy but
be minimized by the administration of analgesics.
gastrointestinal disturbances occur occasionally
larger doses and may be controlled by reducing the
temporarily.
HOW SUPPLIED: 10 mg chewable scored tablets,
bottle of 100. Also 5, 10 and 15 mg oral/sublingual
scored tablets in bottles of 100. 10 mg oral/
sublingual scored tablets also supplied in bottles
of 1,000.
Also available: Cardilate®-P brand Erythrityl
Tetranitrate with Phenobarbital* Tablets
(Scored).
(*Warning—may be habit-forming.)

**Burroughs Wellcome Co.**
Research Triangle Park
North Carolina 27709

# AMA Proposal

### D. State Rate Review Program

This amendment would delete federal funding authority for establishment of State rate review programs.

### E. Certificate of Need and Appropriateness Review

A basic concern with P.L. 93-641 is that certificate-of-need (CON) laws must be adopted by all states. Amendments would make CON a state option.

Other amendments would delete present provisions relating to HSA and State "appropriateness" review of institutional health services and would require a study of certificate of need.

### F. VA and HMO Representation

Two amendments would delete required VA or HMO special representation on HSA governing bodies and SHCCs. Such representation would thus be the choice of the particular body.

### G. Confidentiality of Data

There are inadequate provisions assuring the confidentiality of data gathered or held by HSAs. Since some of this material may be sensitive patient information, it is desirable to have proper protection. Changes to the law would provide for HSA protection of confidential information. The amendment to section 1535 also deletes the extensive review authority of the Secretary over the junctions and operations of the HSA and state agency. The proposed amendment reads, in part:

*Section 1535 is amended to read as follows: "Notwishstanding any provision of this or any other law, no health systems agency, state health planning and development agency or Statewide Health Coordinating Council shall release in any manner to any individual, organization or other entity, any information which would lead to the identification of any individual, hospital or health facility. Each violation of this provision shall be punishable by a fine of $10,000, or five years in prison or both. Any individual aggrieved by a violation of this section may bring a civil action in the Federal District Court for the district in which the individual resides, regardless of the amount of actual damages. The Court may, in its discretion, award actual damages, general damages, punitive damages, and reasonable attorneys' fees."*

*(Continued on page 269)*




# IN THE ILLINOIS AREA, STAPH RESISTANCE HAS NOW REACHED 79%.*

resistance to penicillin G among community-acquired staph infections. Data on file, Bristol Laboratories.

## WHEN YOU CAN'T RULE OUT STAPH, CONSIDER

# TEGOPEN®

# (cloxacillin sodium)

## ..."THE PENICILLIN OF TODAY"

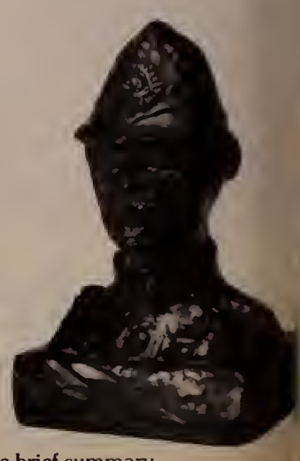
- Effective against nonpenicillinase-producing staphylococci, beta-hemolytic streptococci, and pneumococci.†

†NOTE: The choice of Tegopen should take into consideration the fact that it has been shown to be effective only in the treatment of infections caused by pneumococci, Group A beta-hemolytic streptococci, and penicillin G-resistant and penicillin G-sensitive staphylococci. If the bacteriology report later indicates that the infection is due to an organism other than a penicillin G-resistant staphylococcus sensitive to cloxacillin sodium, the physician is advised to continue therapy with a drug other than cloxacillin sodium or any other penicillinase-resistant semisynthetic penicillin. The clinical significance of *in vitro* data is unknown.

- 10 times more active against strep than staph.

- Well absorbed from the G.I. tract.‡

‡Maximum absorption occurs when Tegopen is taken on an empty stomach, preferably 1-2 hrs. before meals.



Please see brief summary for prescribing information.

**Brief Summary of Prescribing Information**
**Combined TEGOPEN® (cloxacillin sodium)**
**Capsules and Oral Solution**
For complete information, consult Official Package Circular. (12) TEGOPEN 9/11/75

**Indications:** Although the principal indication for cloxacillin sodium is in the treatment of infections due to penicillinase-producing staphylococci, it may be used to initiate therapy in such patients in whom a staphylococcal infection is suspected. (See Important Note below.)

Bacteriologic studies to determine the causative organisms and their sensitivity to cloxacillin sodium should be performed.

**Important Note:** When it is judged necessary that treatment be initiated before definitive culture and sensitivity results are known, the choice of cloxacillin sodium should take into consideration the fact that it has been shown to be effective only in the treatment of infections caused by pneumococci, Group A beta-hemolytic streptococci, and penicillin G-resistant and penicillin G-sensitive staphylococci. If the bacteriology report later indicates the infection is due to an organism other than a penicillin G-resistant staphylococcus sensitive to cloxacillin sodium, the physician is advised to continue therapy with a drug other than cloxacillin sodium or any other penicillinase-resistant semi-synthetic penicillin.

Recent studies have reported that the percentage of staphylococcal isolates resistant to penicillin G outside the hospital is increasing, approximating the high percentage of resistant staphylococcal isolates found in the hospital. For this reason, it is recommended that a penicillinase-resistant penicillin be used as initial therapy for any suspected staphylococcal infection until culture and sensitivity results are known.

Cloxacillin sodium is a compound that acts through a mechanism similar to that of methicillin against penicillin G-resistant staphylococci. Strains of staphylococci resistant to methicillin have existed in nature and it is known that the number of these strains reported has been increasing. Such strains of staphylococci have been capable of producing serious disease, in some instances resulting in fatality. Because of this, there is concern that widespread use of the penicillinase-resistant penicillins may result in the appearance of an increasing number of staphylococcal strains which are resistant to these penicillins.

Methicillin-resistant strains are almost always resistant to all other penicillinase-resistant penicillins (cross-resistance with cephalosporin derivatives also occurs frequently). Resistance to any penicillinase-resistant penicillin should be interpreted as evidence of clinical resistance to all, in spite of the fact that minor variations in *in vitro* sensitivity may be encountered when more than one penicillinase-resistant penicillin is tested against the same strain of staphylococcus.

**Contraindications:** A history of a previous hypersensitivity reaction to any of the penicillins is a contraindication.

**Warning:** Serious and occasionally fatal hypersensitivity (anaphylactoid) reactions have been reported in patients on penicillin therapy. Although anaphylaxis is more frequent following parenteral therapy it has occurred in patients on oral penicillins. These reactions are more apt to occur in individuals with a history of sensitivity to multiple allergens.

There have been well documented reports of individuals with a history of penicillin hypersensitivity reactions who have experienced severe hypersensitivity reactions when treated with a cephalosporin. Before therapy with a penicillin, careful inquiry should be made concerning previous hypersensitivity reactions to penicillins, cephalosporins, and other allergens. If an allergic reaction occurs, the drug should be discontinued and the patient treated with the usual agents, e.g., pressor amines, antihistamines, and corticosteroids.

Safety for use in pregnancy has not been established.

**Precautions:** The possibility of the occurrence of superinfections with mycotic organisms or other pathogens should be kept in mind when using this compound, as with other antibiotics. If superinfection occurs during therapy, appropriate measures should be taken.

As with any potent drug, periodic assessment of organ system function, including renal, hepatic, and hematopoietic, should be made during long-term therapy.

**Adverse Reactions:** Gastrointestinal disturbances, such as nausea, epigastric discomfort, flatulence, and loose stools, have been noted by some patients. Mildly elevated SGOT levels (less than 100 units) have been reported in a few patients for whom pretherapeutic determinations were not made. Skin rashes and allergic symptoms, including wheezing and sneezing, have occasionally been encountered. Eosinophilia, with or without overt allergic manifestations, has been noted in some patients during therapy.

**Usual Dosage:** Adults: 250 mg. q.6h.

Children: 50 mg./Kg./day in equally divided doses q.6h. Children weighing more than 20 Kg. should be given the adult dose. Administer on empty stomach for maximum absorption.

*N.B.:* INFECTIONS CAUSED BY GROUP A BETA-HEMOLYTIC STREPTOCOCCI SHOULD BE TREATED FOR AT LEAST 10 DAYS TO HELP PREVENT THE OCCURRENCE OF ACUTE RHEUMATIC FEVER OR ACUTE GLOMERULONEPHRITIS.

**Supplied:** Capsules—250 mg. in bottles of 100, 500 mg. in bottles of 100. Oral Solution—125 mg./5 ml. in 100 ml. and 200 ml. bottles.

BRISTOL®
BRISTOL LABORATORIES
Division of Bristol-Myers Company
Syracuse, New York 13201

# AMA Proposal

## J. Review of Grant Applications

Under current law, HSAs would review and approve or disapprove applications for funds under a number of grant programs. The provision would be amended to permit HSAs and SHPDAs only to review and comment on such applications; they would not have the power to approve or disapprove. Since the Secretary of HEW in any event has final approval of an application, the amendment would assist primarily in hastening the review process by establishing specific time limits for review.

## K. Payments to HSAs

Under current law, HSAs receive their funding almost completely from the federal government, thus insuring a tight rein on their activities by HEW. Sharing the costs between the federal and state governments (or other non-federal sources) would lessen HEWs control and give to the states a greater voice and interest in planning activities.

## L. Authority of the Secretary of HEW

The powers of the Secretary in the planning process are such that he can exert great control over HSAs, SHPDAs and SHCCs. A series of amendments would lessen that authority. One amendment converts the present "National Health Priorities" into items for "consideration" rather than "priority consideration." Another amendment removes the mandated number of HSA staff and allows for contracts with consultants.

The third amendment allows approval of a State administrative program "substantially" meeting required conditions, rather than absolute compliance. Another amendment removes authority of the SHCC to review the HSA plans.

## N. Designation of Health Service Areas

This series of amendments affect the designation procedures for health service areas. One prohibits interstate HSAs unless the Governors of all the States involved agree to an interstate designation.

Two other amendments give Governors the final approval over designation of HSA boundaries and provide a mechanism for revision of boundaries. ◄




# Thoughts on a Hawaiian Beach

By Linda L. Hughey, M.D./Wilmette

*This is a monthly column which welcomes contributions, comments, and questions from interested readers. Address all correspondence to Dr. Linda Hughey, c/o the Illinois Medical Journal, 55 E. Monroe, Chicago, Ill. 60603.*

Even interns get a vacation. The prudent ones consider their huge debts and neglected families and spend it at home retiling the bathroom floor. Those less prudent (and often single) hop on a plane and go as far as they can afford to go, with at least transient thoughts of never coming back. My recent vacation to Hawaii (much to my surprise, I did come back) provoked a few reflections about why even a bottom-of-the-totem-pole intern needs a break.

Vacation reawakens the forgetful resident to the existence of a world full of healthy people. I watched secretaries playing beach bunny and matrons in muumuus. There are cities filled with well people enjoying life: the hospital slice of life is not all there is to the pie.

Vacation is a time for fantasy. Far away from the hospital (for a change) a resident reflects on what *else* he would like to be doing. Me, I'd be a stewardess and jet around the world responsible only for dinner trays. The ultimate fantasy, of course, is that of never coming home from vacation. No doubt an occasional resident slips through the system that way, but most of us duly trudge homeward. Returning from vacation in some way lends an illusion of free will to our otherwise prescribed existence.

Vacation is a time to put daily living in perspective, to reflect on where we have been and where we are going. We ponder relationships and feelings, habits and lifestyles. Vacations no doubt have ended some marriages and created some others. They can be a time to quit smoking, get back in shape or finish that paper avoided for so long. My own vacation, of course, did nothing so constructive. But I did learn to enjoy the out-of-doors again and made use of a precious opportunity for reflection.

Vacation is a time to catch up on the world . . . to read three newspapers a day, to devour six months of back issues of *Time* magazine, to start at the top and work down the best-seller list. Unfortunately, the first book I read was "COMA"—a mistake for anyone in a surgical specialty with a vivid imagination. Vacationing physicians should stick to such works as "The Grass Grows Greener over the Septic Tank."

Vacation is a time to hatch new ideas and make new plans. New projects come to mind during the mental musings of total relaxation. Since many physicians only relax during their annual vacation, those creative thoughts are at a premium.

Vacation is, at last, a return to reailty. My reality hit hard when, after departing with a lei in 80 degree sunshine, I arrived in a frigid Chicago. Within three hours of arrival I was fleeced by a cab driver, stuck in the snow in my car, and discovered that the car heater had died. Resisting the impulse to take the next flight back to the Hawaiian beach, I dragged myself to work the next day (naturally, I was "on call" as a welcome.) Thoughts of vacation faded quickly in a blur of clinic patients, workups, and all the trivial tasks that keep an intern too busy to think about whether he is happy or not. Spring is on its way and residency, like an Illinois winter, is a passing thing. But even residents deserve to escape on occasion, if only to realize that, viewed from afar, even residency does not look so bad. You, too, deserve a break today.




**I'm just a shadow of what I used to be."**

That is what depressed individuals may feel is the substance of their being. There is no pleasure, no joy — nothing grows — and in the cold shadow of depression their activities are inhibited, while initiative may be eroded or destroyed. The tragedy is that they can see that others are able to live on the brighter side but they, themselves, cannot reach it on their own.

Your experience in treating depression, and Tofranil-**PM** can help light the way.

# Tofranil-**PM**®
imipramine **pamoate**

Geigy

## Unsurpassed effectiveness among tricyclics in relieving symptoms of anxious depression.

Before prescribing Tofranil-PM, please review a summary of the prescribing information on the back of this page.

# Tofranil-PM®
## imipramine **pamoate**

Geigy

As anxiety, agitation, sleep disturbances, and other depressive symptoms are relieved, mood and motivation may be markedly improved.

Patients are usually alert and capable of functioning at more normal levels of behavior.

Tofranil-PM encourages patient compliance because one capsule lasts from bedtime to bedtime.

Good results are usually seen at the starting dose of one 75-mg capsule h.s.

For many patients, dosage can be safely increased to 150 mg daily.

As with all tricyclics, sedation may occur. Please caution patients against driving or operating dangerous machinery.

Each capsule contains imipramine pamoate equivalent to 75, 100, 125 or 150 mg of imipramine hydrochloride.

**Tofranil-PM®**
**brand of imipramine pamoate**

**Indications:** For the relief of symptoms of depression. Endogenous depression is more likely to be alleviated than other depressive states.

**Contraindications:** The concomitant use of monoamine oxidase inhibiting compounds is contraindicated. Hyperpyretic crises or severe convulsive seizures may occur in patients receiving such combinations. The potentiation of adverse effects can be serious, or even fatal. When it is desired to substitute Tofranil-PM, brand of imipramine pamoate, in patients receiving a monoamine oxidase inhibitor, as long an interval should elapse as the clinical situation will allow, with a minimum of 14 days. Initial dosage should be low and increases should be gradual and cautiously prescribed. The drug is contraindicated during the acute recovery period after a myocardial infarction. Patients with a known hypersensitivity to this compound should not be given the drug. The possibility of cross-sensitivity to other dibenzazepine compounds should be kept in mind.

**Warnings:** *Usage in Pregnancy:* Safe use of imipramine during pregnancy and lactation has not been established; therefore, in administering the drug to pregnant patients, nursing mothers, or women of childbearing potential, the potential benefits must be weighed against the possible hazards. Animal reproduction studies have yielded inconclusive results. There have been clinical reports of congenital malformation associated with the use of this drug, but a causal relationship has not been confirmed.

Extreme caution should be used when this drug is given to:

—patients with cardiovascular disease because of the possibility of conduction defects, arrhythmias, myocardial infarction, strokes and tachycardia;
—patients with increased intraocular pressure, history of urinary retention, or history of narrow-angle glaucoma because of the drug's anticholinergic properties;
—hyperthyroid patients or those on thyroid medication because of the possibility of cardiovascular toxicity;
—patients with a history of seizure disorder because this drug has been shown to lower the seizure threshold,
—patients receiving guanethidine or similar agents since imipramine may block the pharmacologic effects of these drugs.

Since imipramine may impair the mental and/or physical abilities required for the performance of potentially hazardous tasks such as operating an automobile or machinery, the patient should be cautioned accordingly.

*Usage in Children:* Tofranil-PM, brand of imipramine pamoate, should not be used in children of any age because of the increased potential for acute overdosage due to the high unit potency (75 mg., 100 mg., 125 mg. and 150 mg.). Each capsule contains imipramine pamoate equivalent to 75 mg., 100 mg., 125 mg. or 150 mg. imipramine hydrochloride.

**Precautions:** It should be kept in mind that the possibility of suicide in seriously depressed patients is inherent in the illness and may persist until significant remission occurs. Such patients should be carefully supervised during the early phase of treatment with Tofranil-PM, brand of imipramine pamoate, and may require hospitalization. Prescriptions should be written for the smallest amount feasible.

Hypomanic or manic episodes may occur, particularly in patients with cyclic disorders. Such reactions may necessitate discontinuation of the drug. If needed, Tofranil-PM, brand of imipramine pamoate, may be resumed in lower dosage when these episodes are relieved. Administration of a tranquilizer may be useful in controlling such episodes.

Prior to elective surgery, imipramine should be discontinued for as long as the clinical situation will allow.

An activation of the psychosis may occasionally be observed in schizophrenic patients and may require reduction of dosage and the addition of a phenothiazine.

In occasional susceptible patients or in those receiving anticholinergic drugs (including antiparkinsonism agents) in addition, the atropine-like effects may become more pronounced (e.g., paralytic ileus). Close supervision and careful adjustment of dosage is required when this drug is administered concomitantly with anticholinergic or sympathomimetic drugs.

Avoid the use of preparations, such as decongestants and local anesthetics, which contain any sympathomimetic amine (e.g., adrenalin, noradrenalin), since it has been reported that tricyclic antidepressants can potentiate the effects of catecholamines.

Patients should be warned that the concomitant use of alcoholic beverages may be associated with exaggerated effects.

Both elevation and lowering of blood sugar levels have been reported.

Concurrent administration of imipramine with electroshock therapy may increase the hazards; such treatment should be limited to those patients for whom it is essential, since there is limited clinical experience.

**Adverse Reactions:** Note: Although the listing which follows includes a few adverse reactions which have not been reported with this specific drug, the pharmacological similarities among the tricyclic antidepressant drugs require that each of the reactions be considered when imipramine is administered.

*Cardiovascular:* Hypotension, hypertension, tachycardia, palpitation, myocardial infarction, arrhythmias, heart block, stroke, falls

*Psychiatric:* Confusional states (especially in the elderly) with hallucinations, disorientation, delusions; anxiety, restlessness, agitation; insomnia and nightmares; hypomania; exacerbation of psychosis.

*Neurological:* Numbness, tingling, paresthesias of extremities; incoordination, ataxia, tremors; peripheral neuropathy; extrapyramidal symptoms; seizures, alterations in EEG patterns; tinnitus.

*Anticholinergic.* Dry mouth, and, rarely, associated sublingual adenitis; blurred vision, disturbances of accommodation, mydriasis; constipation, paralytic ileus; urinary retention, delayed micturition, dilation of the urinary tract.

*Allergic:* Skin rash, petechiae, urticaria, itching, photosensitization (avoid excessive exposure to sunlight); edema (general or of face and tongue); drug fever; cross-sensitivity with desipramine.

*Hematologic:* Bone marrow depression including agranulocytosis; eosinophilia; purpura; thrombocytopenia. Leukocyte and differential counts should be performed in any patient who develops fever and sore throat during therapy; the drug should be discontinued if there is evidence of pathological neutrophil depression.

*Gastrointestinal:* Nausea and vomiting, anorexia, epigastric distress, diarrhea; peculiar taste, stomatitis, abdominal cramps, black tongue.

*Endocrine:* Gynecomastia in the male; breast enlargement and galactorrhea in the female; increased or decreased libido, impotence; testicular swelling; elevation or depression of blood sugar levels.

*Other:* Jaundice (simulating obstructive); altered liver function; weight gain or loss; perspiration; flushing, urinary frequency; drowsiness, dizziness, weakness and fatigue; headache; parotid swelling; alopecia

*Withdrawal Symptoms:* Though not indicative of addiction, abrupt cessation of treatment after prolonged therapy may produce nausea, headache and malaise.

**Dosage and Administration:** In adult outpatients, therapy should be initiated on a once-a-day basis with 75 mg./day. This may be increased to 150 mg./day which is the dose level which usually obtains optimum response. If necessary, dosage may be increased to 200 mg./day. Dosage should be modified as necessary by clinical response and any evidence of intolerance. Daily dosage may be given at bedtime, or in some patients in divided daily doses.

Hospitalized patients should be started on a once-a-day basis with 100-150 mg./day and may be increased to 200 mg./day. Dosage should be increased to 250-300 mg. daily if there is no response after two weeks.

Following remission, maintenance medication may be required for a longer period of time at the lowest dose that will maintain remission. The usual adult maintenance dosage is 75-150 mg./day on a once-a-day basis, preferably at bedtime.

In adolescent and geriatric patients, capsules of Tofranil-PM, brand of imipramine pamoate, may be used when total daily dosage is established at 75 mg. or higher. It is generally unnecessary to exceed 100 mg./day in these patients. This dosage may be given once a day at bedtime or, if needed, in divided daily doses.

**How Supplied:** Tofranil-PM, brand of imipramine pamoate: Capsules of 75, 100, 125 and 150 mg. (Each capsule contains imipramine pamoate equivalent to 75, 100, 125 or 150 mg. of imipramine hydrochloride.)
(B) 98-146-840-A(9 75) 667120

**For complete details, including dosage and administration, please refer to the full prescribing information.**

GEIGY Pharmaceuticals
Division of CIBA-GEIGY Corporation
Ardsley, New York 10502

Printed in U.S.A. (10-77) TO 12889

"In a major study just completed in Canada, aspirin reduced the chances of stroke in high-risk men—but not in women...A Harvard neurologist urges anticoagulants for patients with atrial fibrillation...Coal strike drives MDs from Appalachia...A mysterious ailment affecting people who live in mobile homes has been traced to formaldehyde used in construction...A University of Wisconsin psychiatrist reports on the effectiveness of jogging for the treatment of depression..."

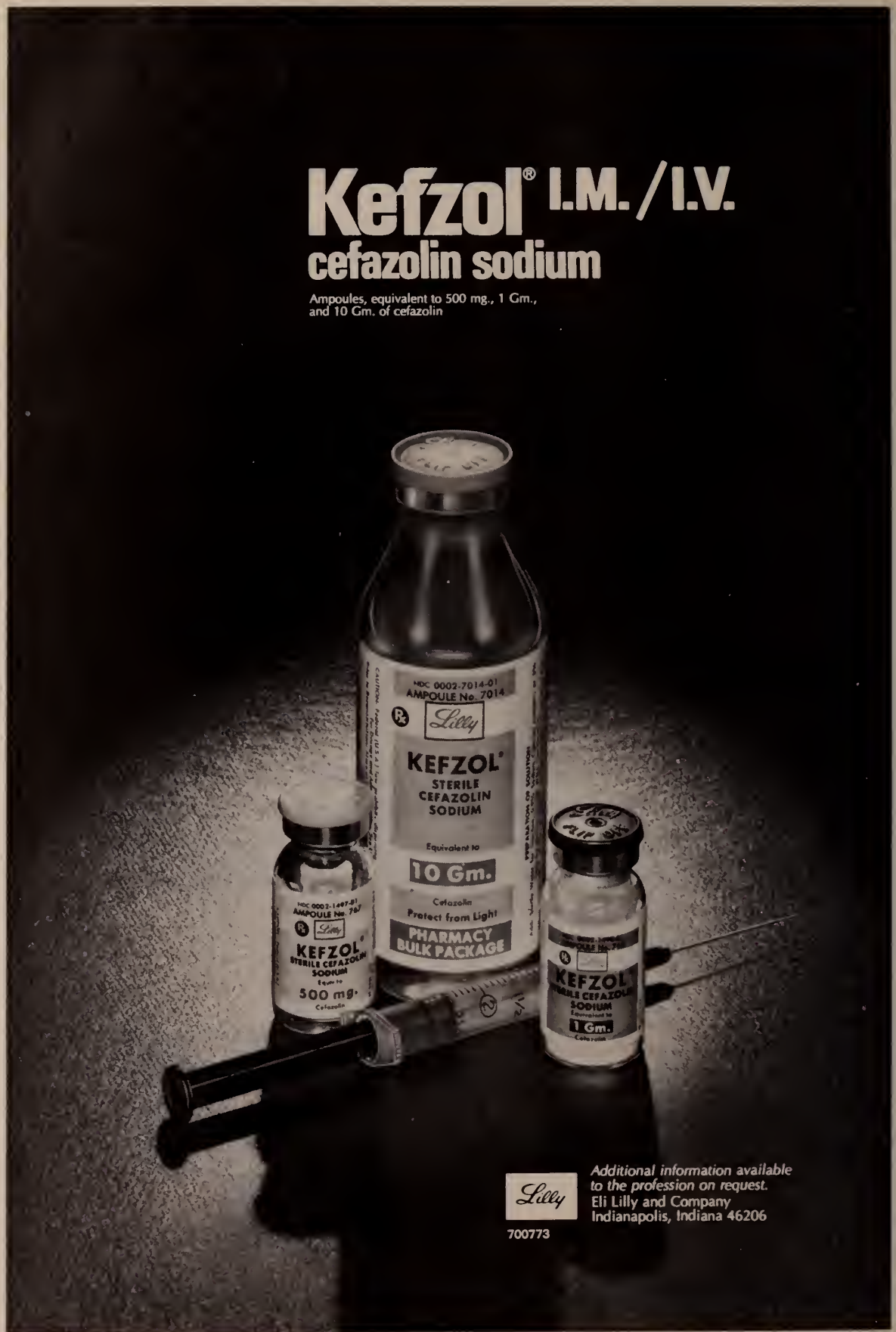
**Important things are happening that you should know about right away. You'll find them on your desk every two weeks in Medical World News, the newsmagazine of medicine.**

**Read this one first.**

**medical world news**

A McGraw-Hill publication

McGraw-Hill


Kefzol® I.M./I.V.
cefazolin sodium
Ampoules, equivalent to 500 mg., 1 Gm.,
and 10 Gm. of cefazolin
NDC 0002-7014-01
AMPOULE No. 7014
Lilly
KEFZOL®
STERILE
CEFAZOLIN
SODIUM
Equivalent to
10 Gm.
Cefazolin
Protect from Light
PHARMACY
BULK PACKAGE
KEFZOL
SODIUM
500 mg.
KEFZOL
SODIUM
1 Gm.
Additional information available
to the profession on request.
Eli Lilly and Company
Indianapolis, Indiana 46206
700773

# Imperial Europe Adventure

## *AUSTRIA – HUNGARY – YUGOSLAVIA*

***An eleven-day Luxury Holiday to the Europe of the Beautiful Blue Danube and Dalmatian Coast.***

***VIENNA*** *... City of Dreams and Waltzes. Shop along the Kartnerstrasse. Sample schnitzel and Sachertorte. See emerald Alpine meadows or imperial palaces.*

***BUDAPEST*** *... Wine, Women and Gypsy Violins. Live as the aristocrats did – dine on magnificent goulash and drink "Bull's Blood Wine" to the strains of soulful violins. Wander through the cafe lined streets of the twin cities of Buda and Pest or cruise down the River Danube.*

***DUBROVNIK*** *... The Riviera of the Dalmatian Coast. Relive history in the ancient walled city amidst churches, palaces and restaurants. Wander the "Placa" and discover peasant handicraft bargains. See magnificent Kotor Fjord and the ancient island village of Sveti Stefan.*

*A remarkable journey full of European elegance and Bohemian atmosphere.*

**We depart from Chicago on September 2, 1978 and return on September 12, 1978.**

**Price: $1198**

*Send to:* Illinois State Medical Society
55 East Monroe
Chicago, Illinois 60603

*Enclosed is my check for $ _____ $100 per person as deposit.*

*Names* _____

*Address* _____

*City* _____ *State* _____ *Zip* _____

*Space Strictly Limited – Make Reservations Now*

A Non-Regimented **INTRAV** Deluxe Adventure



# Professional Liability

*It is sometimes reassuring to find that today's woes were also yesterday's laments. This column will reprint verbatim a series of articles which were initiated in the September, 1914, IMJ. Historical perspectives on a modern problem might prove enlightening.*

## ACTIONS FOR CIVIL MALPRACTICE

*Second Article**

ROBERT J. FOLONIE, LL. B.
CHICAGO

The increased number of unwarrantable actions for malpractice within recent years is, in part, due to causes beyond the control of the physician.

Such causes are more or less sporadic and present new and varying factors from time to time.

Prominent among such causes at the present time is the trend of legislation of a paternalistic type. In Illinois the act providing for compensation to injured employees was followed so immediately by a large number of baseless malpractice claims as to preclude any inference that it was a mere coincidence.

It is doubtful that there was opportunity in so limited a period for these suits to have been outgrowth of a feeling of lessened responsibility on the part of the working man, unless it may be assumed that the previous agitation had created such a spirit before it was put into the form of legislative enactment. It is more likely that these claims were precipitated through the loss of practice of lawyers accustomed to handling suits for personal injury against employers, who, in a state of panic, finding their means of livelihood abruptly taken away, scampered for other pastures, no matter how scanty their verdure. Of more importance to the actively practicing physician is the ultimate result after the sense of newness has worn off.

The beneficient effect of legislation of the type indicated within reasonable limits is generally conceded by students of sociology. Those upon whom its attendant but inescapable results fall must bear it with patience.

Almost every social revolution bears heavily on members of the learned professions, and these increasing evils we must bear with as much fortitude as possible, until eventually the practice of medicine will become primarily a profession under governmental control.

There can be no doubt that the selection of the physician to attend the injured employee without the consent of the servant and quite frequently at the instance of the Casualty Co. insuring the employer, does not create the feeling of trust which is felt when the physician is of the patient's own selection.

The lessening of the personal equation without any corresponding regulation by the estate leaves the physician the subject of suspicion and often of antagonism which must prove a great hindrance in effecting a cure and also increasing the likelihood of claims of malpractice.

A large number of suits have already been instituted against physicians (some at the instigation of employers or their insurers) and suits commenced by the employee against the employer, claiming malpractice of the physician designated by the latter.

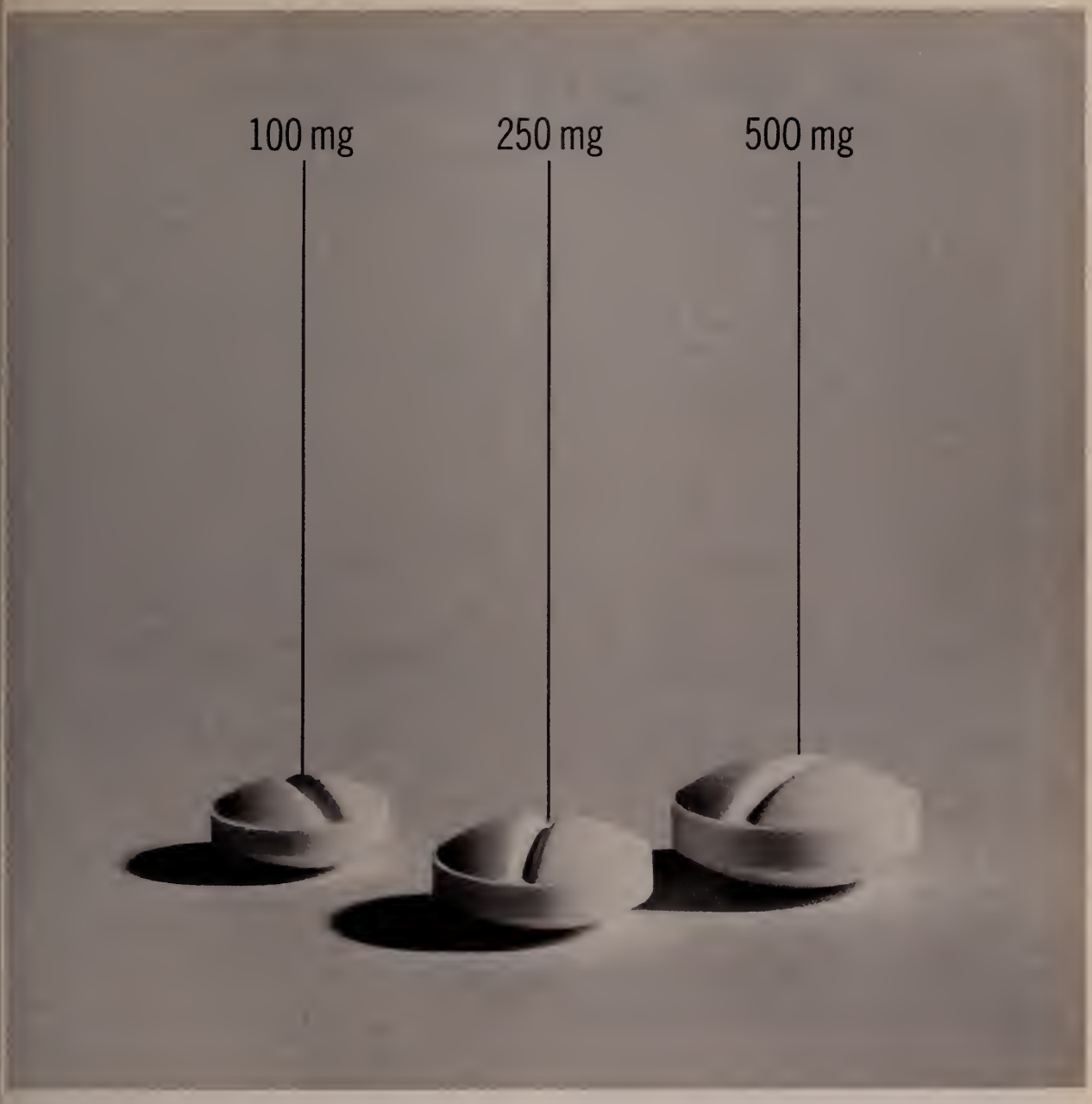
It is regrettable to record that in many cases where compensation is sought from the employer by the employee, the defense of malpractice is interposed, not in good faith, but as a club to secure reduction of the physician's bill or to cause it to be writhdrawn.

It is to be borne in mind as a practical procedure, that under the Illinois Compensation Act, the employer is not responsible for hospital bills and physician's bills in excess of $200.00. This amount is the limit of jurisdiction of a justice of the peace, and no cross demands can there be filed in large amount to frighten the physician.

It has been a frequent experience of physicians suing for bills in other courts, that upon presentation of a claim for a comparatively small amount, is met with a counter-claim of $10,000 and even more, thereby precipitating a suit which most often has no legitimate basis in law or fact, but which causes the physician so much concern as to prove more than an irritation.

So many actions for malpractice are precipitated through a desire of the patient or person responsible for the bill to escape its payment, or reduce the amount to be paid, that a separate article will be devoted to the question of charges against clients and their relation to the making of claims for civil malpractice.

*Reprinted from the October, 1914, issue of the Illinois Medical Journal.




# Tolinase®
## tolazamide, Upjohn

Please contact your Upjohn representative for additional product information.

Upjohn

J-5695-6

©1977 THE UPJOHN COMPANY

# A Matter of Principles

*The American Medical Association Judicial Council has proposed amendments to the AMA Principles of Medical Ethics. The changes will be considered at the AMA House of Delegates meeting in June, 1978.*

*The AMA is seeking comment from physicians on the proposed changes, which were promulgated "to modernize the language of the Principles and to clarify their meaning." The current principles are printed below, immediately followed by the proposed revisions.*

*Please forward your comments to: Bruce Nortell, Secretary, AMA Judicial Council, American Medical Association, 535 N. Dearborn Street, Chicago 60610.*

## *Present Principles of Medical Ethics*

Preamble. These principles are intended to aid physicians individually and collectively in maintaining a high level of ethical conduct. They are not laws but standards by which a physician may determine the propriety of his conduct in his relationship with patients, with colleagues, with members of allied professions, and with the public.

Section 1. The principal objective of the medical profession is to render service to humanity with full respect for the dignity of man.

Physicians should merit the confidence of patients entrusted to their care, rendering to each a full measure of service and devotion.

Section 2. Physicians should strive continually to improve medical knowledge and skill, and should make available to their patients and colleagues the benefits of their professional attainments.

Section 3. A physician should practice a method of healing founded on a scientific basis; and should not voluntarily associate professionally with anyone who violates this principle.

## Proposed New Principles of Medical Ethics

Preamble. These principles are intended to aid physicians in maintaining high standards of ethical professional conduct in their relations with patients, colleagues, members of allied professions, and the public.

One. The primary objective of the medical profession is to serve patients competently with full respect for their dignity.

Two. Physicians should strive continually to improve medical knowledge and skill and to make available to patients and colleagues the benefits of their professional attainments.

Three. A physician should not engage or participate in treatment which is not founded on a scientific basis.

Section 4. The medical profession should safeguard the public and itself against physicians deficient in moral character or professional competence. Physicians should observe all laws, uphold the dignity and honor of the profession and accept its self-imposed disciplines. They should expose, without hesitation, illegal or unethical conduct of fellow members of the profession.

Four. The medical profession should protect the public and itself against physicians deficient in moral character or professional competence. Physicians should observe all laws, uphold the dignity and honor of their profession, and voluntarily accept its self-imposed disciplines. Physicians should expose, without hesitation, illegal or unethical conduct of members of the profession.

Section 5. A physician may choose whom he will serve. In an emergency, however, he should render service to the best of his ability. Having undertaken the care of a patient, he may not neglect him; and unless he has been discharged he may discontinue his services only after giving adequate notice. He should not solicit patients.

Five. Physicians may choose when they will serve except in emergencies. Competent services should be provided and continued until the physician is discharged or services are discontinued after giving adequate notice. A physician should not attempt to obtain patients by deception.

Section 6. A physician should not dispose of his services under terms or conditions which tend to interfere with or impair the free and complete exercise of his medical judgment and skill or tend to cause a deterioration of the quality of medical care.

Six. Physicians should resist restraints which interfere with medical judgment and skill or cause deterioration of the quality of medical care.

Section 7. In the practice of medicine a physician should limit the source of his professional income to medical services actually rendered by him, or under his supervision, to his patients. His fee should be commensurate with the services rendered and the patient's ability to pay. He should neither pay nor receive a commission for referral of patients. Drugs, remedies or appliances may be dispensed or supplied by the physician provided it is in the best interest of the patient.

Seven. Physicians are entitled to be compensated fairly for personally providing or supervising the medical care of patients. A commission should not be paid nor accepted for the referral of patients.

Section 8. A physician should seek consultation upon request; in doubtful or difficult cases; or whenever it appears that the quality of medical service may be enhanced thereby.

Eight. A physician should seek consultation upon request or whenever it may benefit the patient.

Section 9. A physician may not reveal the confidences entrusted to him in the course of medical attendance, or the deficiencies he may observe in the character of patients, unless he is required to do so by law or unless it becomes necessary in order to protect the welfare of the individual or of the community.

Nine. A physician may not reveal confidences entrusted during medical attendance or deficiencies observed in the character of patients, unless required to do so by law or it becomes necessary in protecting the welfare of the patients or the community.

Section 10. The honored ideals of the medical profession imply that the responsibilities of the physician extend not only to the individual, but also to society where these responsibilities deserve his interest and participation in activities which have the purpose of improving both the health and well-being of the individual and the community.

Ten. In addition to providing care to patients, the physician has a social responsibility to participate in activities intended to improve the health of the community.

# Practice Productivity Inc.

# one day WORKSHOP

# BUSINESS ESSENTIALS FOR A MEDICAL OFFICE

## FOR YOUR MEDICAL OFFICE ASSISTANTS

**8:45 a.m. to 5:00 p.m.**

| | | |
|---|---|---|
| May 16, 1978 | Chicago | Hyatt Regency |
| May 17, 1978 | Champaign | Ramada Inn |
| May 18, 1978 | Springfield | Sheraton Motor Inn |
| May 25, 1978 | Chicago | Watertower Hyatt |

OFFICE MANAGERS
RECEPTIONISTS
MEDICAL SECRETARIES
BOOKKEEPERS
INSURANCE CLERKS
NURSES

**This program has been approved for Continuing Education Units by AAMA**

**TOPICS: Telephone Management, Appointment Scheduling, Medical Records, Personnel, Billing Systems and Collection, Insurance Claim Processing.**

**Practice Productivity Inc.** is a national management consulting firm located in Atlanta whose only clients are physicians engaged in the private practice of medicine. Practice Productivity offers educational and motivational workshops in sound business concepts to physicians, medical office managers, and medical assistants. Practice Productivity also provides nation-wide individual consulting to physicians at their private practice.

For Further information, contact:
**Duane M. Johnson, PhD, Executive Vice-President, Practice Productivity, Inc.**

---

**Registration Form**

| Name | Position | City Will Attend | Date Will Attend |
|---|---|---|---|
| 1. | | | |
| 2. | | | |
| 3. | | | |

Name of Practice: _____

Specialty: _____ Telephone: (_____) _____

Address: _____

City: _____ State: _____ Zip: _____

Full tuition fee of $ _____ is enclosed at $75 per registrant. Tuition includes course materials and luncheon and MUST ACCOMPANY THIS FORM. (There is a $10 handling fee deducted on all refunds for cancellations received at least one week in advance of course; no refund thereafter.)

**Practice Productivity Inc.**

2000 Clearview Avenue, Atlanta, Georgia 30340, Telephone (404) 455-7344 or Toll Free 800-241-6228



# RESIDENTS

1500 bed chronic disease hospital in Chicago suburbs with acute and rehabilitation services has openings available for July 1st, 1978.

Residencies approved by Illinois State Licensing Board for Geriatric Medicine and Chronic Diseases under direction of Dodda B. Rao, M.D. and Adult Cardiology under direction of Aldo A. Luisada, M.D. with rotation through services.

A major affiliate of two medical schools.

Foreign graduates must have VQE or ECFMG certificate and immigrant visa status.

Salary dependent on previous post-graduate training and experience. Excellent fringe benefits.

Direct all inquiries with curriculum vitae to:

JACK SOBEL, M.D., F.A.C.P.
Medical Director & Chief of Staff



## OAK FOREST HOSPITAL

15900 S. CICERO AVE.
OAK FOREST, ILL. 60452

A division of the Health and Hospitals Governing Commission of Cook County

An Equal Opportunity Employer M/F

**Sponsored by the American Medical Association and Illinois State Medical Society**
5 PM-9 PM, Thursday, May 25, 1978

8 AM-4 PM, Friday, May 26, 1978
Marriott O'Hare Motor Hotel
8535 West Higgins Road
Chicago, Illinois

## Objective:

The purpose of the program is to help you diagnose and evaluate the effects upon the individual of air pollution from community and home sources.

From the standpoint of the clinician's assessment, illnesses associated with these sources are far less easily verified than illnesses caused by smoking or a work environment. Epidemiologists and medical researchers have shown that certain susceptible individuals can be affected by air pollution in the community and by airborne contaminants from home heating and cooking equipment.

The program will include tabletop demonstrations and didactic lectures along with a modified rounds presentation featuring pollution-sensitive patients accompanied by their physicians.

As an organization accredited for continuing medical education, the American Medical Association certifies that this continuing medical education activity meets the criteria for nine (9) credit hours in Category 1 of the Physician's Recognition Award of the American Medical Association. This program has also been accredited by the American Academy of Family Physicians.

Although the program covers parts of two days, credit for each day will be computed separately. Participants at the Thursday evening session will receive 2 credits while those at the Friday session will receive 7 credits.

For further information please contact the ISMS Division of Medical Service, 55 E. Monroe, Suite 3510, Chicago 60603.



# AIR POLLUTION & PATIENT MANAGEMENT

IMJ
Illinois Medical Journal
Vol. 153, No. 4, April, 1978

## Treatment with $H_2$ Receptor Antagonists

# Zollinger-Ellison Syndrome

By John K. Siepler, Pharm.D., Philip Donahue, M.D.,
Keith Campagna, Pharm.D., and C. T. Bombeck, M.D./Chicago

*Patients who have intractable ulcer disease secondary to hypersecretory states such as Zollinger-Ellison Syndrome are usually difficult to treat medically. It is often difficult to surgically remove all of the gastrin secreting tumor. At the University of Illinois Hospital, a patient with Zollinger-Ellison Syndrome is being treated with $H_2$ receptor antagonists rather than surgery. A summary of his case and long term follow-up is presented.*

The patient is a 62-year-old white male who underwent a 70% gastrectomy for an intractable duodenal ulcer in 1959. His symptoms were controlled until 1971, when a marginal ulcer perforated and required emergency surgery. In the spring of 1974, a truncal vagotomy was performed for persistent symptoms of epigastric pain relieved by food or antacid ingestion. A large recurrent marginal ulcer and an elevated serum gastrin were discovered in the summer of 1975. Zollinger-Ellison Syndrome was diagnosed. A large chest mass was also seen on chest X-ray and he was transferred to the University of Illinois Hospital, where bronchoscopy revealed a tumor mass occluding the left upper lobe bronchus. Biopsy revealed squamous cell carcinoma.

### Physical Examination

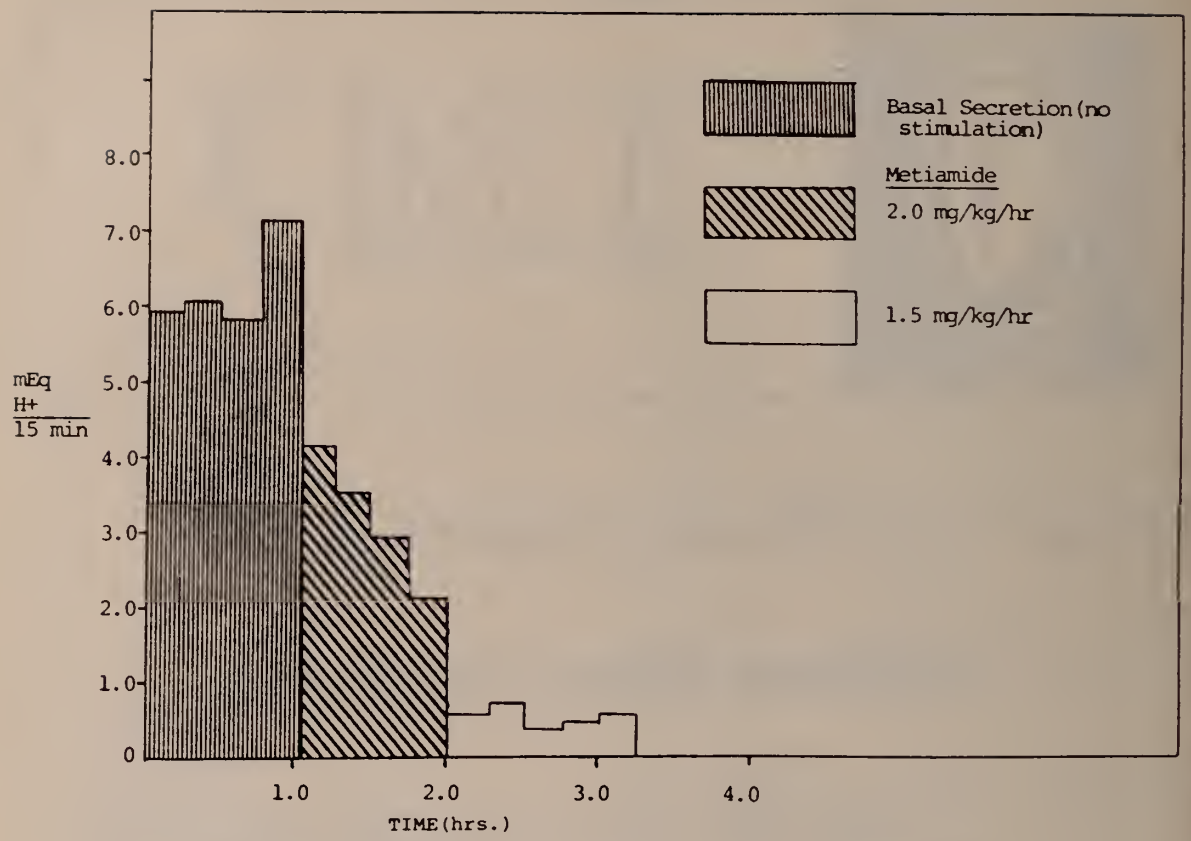
Examination revealed a 62-year-old white male in no acute distress who had lost 15 pounds in the two weeks prior to admission, and weighed 125 pounds.

*Problems:* (1) Zollinger-Ellison Syndrome with gastric hypersecretion; (2) Recurrent marginal ulceration secondary to #1; and (3) Bronchogenic carcinoma of the left lung.

### Hospital Course

A thoracotomy was planned for resection of

FIGURE 1




the bronchogenic carcinoma. Prior to surgery, gastric secretion was controlled with metiamide. Figure 1 shows the patient's response to intravenous infusion of two doses of metiamide. Excellent secretory control was obtained with the 1.5 mg/kg/hr infusion rate. A left upper lobectomy was performed. Postoperatively, inhibitory effect of various doses of oral metiamide on gastric secretion was measured. Table 1 shows how several different doses of metiamide inhibited gastric acid production. The patient was discharged on metiamide 1300 mg/day.

**Table 1**

| Metiamide dose (mg) | % inhibition, Gastric HCl |
|---|---|
| 200 | 44 |
| 300 | 67 |
| 400 | 89 |

The patient was stable until November, 1975, when cimetidine was substituted. (Cimetidine inhibition of gastric acid secretion was tested and also demonstrated excellent ability to inhibit gastric acid secretion.) For the past 14 months he has been maintained on 1600 mg of cimetidine daily, that has recently been reduced to 1200 mg daily. His control has been excellent except for a period of time in July, 1976, when the drug was withheld for diagnostic tests. Endoscopy at that time showed that his marginal ulcer, which was large enough to admit the tip of the endoscope (44fr), had not healed. Endoscopy in December of 1976 showed the ulcer crater to be almost healed, and in April, 1977, only a shallow fibrin base remained of this once huge ulcer. At present he is well, and free of pain. The patient takes 400 mg of cimetidine three times daily, and weighs 158 pounds. He continues to refuse any consideration of completion gastrectomy (as he has been recovering from the thoracotomy).

### Clinical Use in Peptic Ulcer Disease

The $H_2$-Receptor anatgonists have been shown to inhibit gastric acid and pepsin release in animals.[1] Tests with both normal patients and in patients with peptic ulcer disease have shown that $H_2$-Receptor antagonists caused a marked reduction in both basal and stimulated acid release.[2-5] Tests in animals have shown experimentally-induced gastrointestinal ulcerations to heal more quickly with $H_2$-Receptor antagonist administration than with a placebo. Since there seems to be good evidence that $H_2$-Receptor antagonists inhibit gastric acid release, a review of effectiveness in clinical trials follows.

Patient response to therapy in duodenal ulcer disease is monitored by two basic methods—lessened pain and objective demonstration of ulcer healing or ulcer size reduction.

Since epigastric pain is a common symptom of a duodenal ulcer, its relief is essential to the subjective assessment of a patient's progress. Pounder and associates treated thirty patients with duodenal ulcers for five to eight weeks.[4] He used either metiamide 1.0 gm daily or placebo. A significant reduction in epigastric pain was noted in the 15 patients who received metiamide. They found that both night-time and day-time pain, as well as antacid consumption, were significantly reduced by 200 mg tid plus 400 mg hs of metiamide. This study made no attempt to assess healing of duodenal ulcers. The finding was significant, however, as the dramatic pain reduction illustrated by the metiamide group indicated that further investigation of clinical response to $H_2$-Receptor antagonists was warranted. That same group studied the responses of eleven patients to cimetidine. All eleven had endoscopically confirmed benign gastric ulcers and were treated for six weeks with cimetidine, 200 mg qid or 400 mg qid. At the end of the six weeks a second endoscopy found all ulcers to be healed. They also confirmed a previous finding that nocturnal ulcer pain was relieved in most of the patients on cimetidine. While this report is not a double blind investigation, their endoscopically proven results are impressive. Further controlled, double-blind trials of cimetidine in duodenal ulcer disease are warranted.

As previously stated, total gastrectomy is the current treatment modality for Zollinger-Ellison Syndrome. The object of this surgery is absolute inhibition of the gastric hypersecretory state. This same reasoning has supported various degrees of surgical intervention in other peptic ulcerative diseases, (principally duodenal ulcer). If the destructive effects of the increased acid and pepsin load on the gastro-intestinal lining may be effectively abated by $H_2$-Receptor antagonists, these drugs may assume an important role in the treatment of peptic ulcer diseases.

### Clinical Use of Metiamide in Zollinger-Ellison Syndrome (Z.E.)

The literature contains detailed reports of ten patients with Z.E. treated with metiamide. (See Table 2)

**Table 2**

| Case | Length of Treatment (months) | Dose (mg/d) | % inhibition of acid | Reference |
|---|---|---|---|---|
| Thompson | 1 | 800 | 90% | 6 |
| Halloran | few days | 125mg/hr | — | 7 |
| Mainardi | one dose | 200 | 87% | 8 |
| Bonfils | 11 | 600 (max.) | 75% | 9 |
| Blair | 6 | 1,200 | — | 10 |
| Blair | 6 | 800-1,200 | — | 10 |
| Blair | 6 | 800-1,200 | — | 10 |
| Richardson | 5 | 1,300 | 100% | 11,12 |
| Richardson | 10 | 1,800 | 90% | 11,12 |
| Richardson | 3 weeks | 1,300 | 97% | 11,12 |
| Our patient | 3 | 1,300 | 44%—(200mg dose)<br>67%—(300mg dose)<br>89%—(400mg dose) | |
| | | **Cimetidine** | | |
| Our patient | 17 | 1,600-1,200* | 97% | |

**Present dose*

The first published report is a 41-year-old man who had recurrent peptic ulcerations.[6] Zollinger-Ellison Syndrome was diagnosed. A 1.5 mg/Kg/hr infusion of metiamide brought a 90% reduction of his basal acid secretion. He was subsequently put on 200 mg of metiamide qid and endoscopy demonstrated healing of the ulcer in one month. No mention is made of chronic therapy with metiamide.

The next patient, reported in February, 1975, had developed a gastrojejunocolic enterocutaneous fistula following gastro-intestinal surgery.[7] Subsequently, a marked electrolyte disturbance was noted, due to the large acid output of the fistula secondary to his gastric hypersecretion. The patient did not respond to a constant infusion of 0.8 mg/Kg/hr, but when the dose was increased to 2.0 mg/Kg/hr the gastric output decreased substantially. This was helpful in correcting electrolyte balance prior to the performance of total gastrectomy. This patient's suppression of gastric fluid fistula output in massive volumes is consistent with our observations. Our patient not only received metiamide for a very short period prior to surgery but has been maintained on histamine $H_2$-Receptor antagonists for a total of twenty-two months.

The next patient is a 36-year-old male who, when diagnosed, received a dose of metiamide.[8] The patient demonstrated an 87% decrease in gastric acid output during the first hour following the metiamide administration. Volume of output decreased from 157 ml/15 min. to 22 ml/15 min. Our patient had a 67% decrease in acid production with the same dose.

In France, Bonfils treated a Z.E. patient intermittently for 11 months until a total gastrectomy was performed.[9] The patient had long-standing diarrhea from gastric hypersecretion. He had elevated serum gastrin levels and duodenal ulceration. Metiamide at a dose of 600 mg/day inhibited 75% of the gastric acid secretion, but the patient only received 200 mg/day for much of the time. The authors resorted to total gastrectomy because the patient developed a duodenal ulcer during metiamide treatment. This apparent failure may have occurred because a very low dose was administered: one-half the dose our patient required.

Blair and associates also report using metiamide successfully in three patients with Zollinger-Ellison Syndrome.[10] They use 0.8-1.2 gm per day of metiamide and demonstrated healing after six weeks of therapy in two of the three patients' ulcers. The third patient developed a leukopenia and therapy was withdrawn. At the time of report, the two successfully treated patients had been treated continuously for six months. Richardson reports three patients with Z.E. who were treated with metiamide.[11] The first patient was treated with 300 mg tid and 400 mg hs of metiamide. The second patient was treated with 1800 mg/day of metiamide. Both of these patients were being maintained on $H_2$-Receptor antagonists in April, 1976.[12] Because metiamide was withdrawn from clinical use in November, 1975, they are now being treated with cimetidine.

Our patient has done remarkably well while on cimetidine. Because of cimetidine's longer serum half-life he has been able to sleep through the night, free of pain, for the first time in two years. In contrast, metiamide at a dose of 400 mg hs relieved his nocturnal pain for only 4 to 5 hours. He has not had any epigastric pain in the past eight months.

However, endoscopy performed in July, 1976, and repeated in December, 1976, showed that his marginal ulcer had not completely healed. This finding is similar to Bonfil's experience, except that we have been using higher doses of cimetidine. As of this date our patient still remains pain-free, and repeat endoscopy in April, 1977, showed 85% healing of the ulcer.

**Discussion**

While many patients have done very well when treated with $H_2$-Receptor antagonists, a question must be raised before cimetidine is recommended as effective treatment for Zollinger-Ellison Syndrome. Its relative freedom from side-effects must be assured. We noted only a transient headache that appeared to correspond to the initiation of cimetidine therapy and resolved as it continued. If this is the major side-effect encountered, cimetidine may, indeed, be a safe drug.

An "escape" of $H_2$-Receptor antagonist control of gastric acidity has also been reported.[4] These patients required higher doses to control gastric acidity after lengthy treatment (one month), than were required when therapy was initiated; ulcer healing was not evaluated in this group of patients.

If a patient with Zollinger-Ellison Syndrome contemplates a nonsurgical treatment with cimetidine, one thing must be made clear to the patient. It will be chronic, long-term treatment, and may be required for the remainder of the patient's life. The fact that total gastrectomy will

prevent any further ulcer complications must be evident to the patient. Surgery is not without some risks, however, and the patient with higher surgical risk may be a better candidate for cimetidine treatment than for surgery.

## Conclusion

The Histamine $H_2$ antagonists are a new and unique class of drugs that may revolutionize the treatment of peptic ulcer disease. Their demonstrated efficacy in duodenal ulcers and gastric ulcers is exciting, and their use in Zollinger-Ellison Syndrome is promising. Cimetidine was released by the FDA in August, 1977, and will probably find wide application in the management of all types of ulceration of the gastrointestinal tract. ◄

### References


1. Magel, D. F.: "Metiamide: Antagonist of Histamine Stimulated Gastric Acid Secretion," *Ann. Surg.* 182-627, 1975.
2. Thjodleifsson, B.: "Aspects of the Effect of Metiamide on Pentagastrin Stimulated Basal Gastric Secretion of Acid and Pepsin in Man," *Gut* 16:501, 1975.
3. Mainardi, M., *et al*: "Metiamide, an $H_2$-Receptor Blocker, an inhibitor of Basal and Meal Stimulated Gastric Acid Secretion in Patients with Duodenal Ulcer," *N. Engl. J. Med.* 291:373, 1975.
4. Pounder, R. E., *et al*: "24 hours Control of Intragastric Acidity by Cimetidine in Duodenal Ulcer Patients," *Lancet* 2:1069, 1975.
5. Henn, R. M., *et al*: "Inhibition of Gastric Acid Secretion by Cimetidine in Patients with Duodenal Ulcer," *N. Engl. J. Med.* 293:371-375, 1975.
6. Thompson, M. H., *et al.*: "Metiamide in Zollinger-Ellison Syndrome," *Lancet* 1:35, 1975.
7. Halloran, L. G., *et al*: "Metiamide in Zollinger-Ellison Syndrome," *Lancet* 1:231, 1975.
8. Mainardi, M., *et al*: "Inhibition of Gastric Acid Secretion by Metiamide in Zollinger-Ellison Syndrome," *Am. J. Dig. Dis.* 20:280, 1975.
9. Bonfils, S., *et al.*: "Syndrome de Zollinger-Ellison traite Medicalement par un inhibiteur des Recepteurs $H_2$ a l'histamine," *La Nouvell presse Medicale* 33:2377, 1975.
10. Blair, E. L., *et al*: "$H_2$Receptor antagonists in Z.E." *Am. J. Dig. Dis.* 20:1123, 1975.
11. Richardson, C. T. and Walsh, J. M.: "The Value of a Histamine $H_2$-Receptor Antagonist in the Management of Patients with Zollinger-Ellison Syndrome," *N. Engl. J. Med.* 294:133-135, 1976.
12. Richardson, C. T., and Walsh, J. M.: "$H_2$ Receptor Antagonists for Z.E.," *N. Engl. J. Med.* 294:1011, 1976.



JOHN K. SIEPLER, Pharm.D., is an assistant professor of pharmacy practice, University af Illinois College of Pharmacy and Hospital Pharmacy Services. He is a member of the American Society of Hospital Pharmacists, American College of Clinical Pharmacology and American Association of Colleges of Pharmacy.



PHILIP E. DONAHUE, M.D., is an assistant professor with the University of Illinois Abraham Lincoln School of Medicine. An attending staff member at the University of Illinois and West Side Veterans Administration Hospitals, Doctor Danahue is certified by the American Board of Surgery. He is a member of the Chicago Gastroenterological Society, the Association of V.A. Surgeons and the American Society of Gastrointestinal Endoscopy.

KEITH CAMPAGNA, Pharm.D., is an assistant professor of pharmacy practice and assistant director of Hospital Pharmacy for Patient Care Services at the University of Illinois Medical Center. He is a member of the American Society of Hospital Pharmacists, American Association of Colleges of Pharmacy, Illinois Council of Hospital Pharmacists and the Northern Illinois Society of Hospital Pharmacists.

CHARLES T. BOMBECK III, M.D., is a general surgeon and professor of surgery affiliated with the University of Illinois Abraham Lincoln School of Medicine. A Diplomate af the American Board of Surgery, Doctor Bombeck is chief of the division of surgical gastroenterology and also examiner liaison officer and chief examiner of the department of surgery.



LEASE NOW

PORSCHE 911

The ultimate sports machine. We have the largest inventory in the midwest.



AUDI 5000

The sensible luxury car. All types of leases available, long or short term.



NOW RESERVING LEASE DATES FOR PORSCHE 928's!

Doctors have special transportation needs and we have been filling them with incomparable automobiles for years. Leasing your next car makes good economic sense and we'd like to show you why.

O'HARE INTERNATIONAL AUTOS

The Midwest's Largest Porsche, Audi and Mazda Dealer

CALL VINCE PISHA (312) 297-2880

# The Illinois Experience With MECO

By David M. Roxe, M.D.

The distribution of physicians in various specialties has been a concern of the public, politicians, educators, and medical societies. It is frequently said that medical schools should be training more general practitioners and fewer specialists, and that doctors should be encouraged to settle in small communities that lack easy access to health care. The Illinois State Medical Society (ISMS) has actively supported a program entitled MECO (Medical Education, Community Orientation). This program has been sponsored by the American Medical Student Association and, in Illinois, has received administrative and staff support from ISMS. The overall purposes of the project are:

1. To provide an opportunity for students to learn about medical practice and hospital operation before their clinical years of training.

2. To provide an opportunity for practicing physicians to actively participate in undergraduate medical education.

3. To provide an opportunity for community hospitals to expose medical students to health care delivery and career practice opportunities.[1]

Medical students who participate in MECO make application for the period between the first and second, or between the second and third years of school. At the time of application they have virtually no clinical experience, so that the MECO project provides their initial orientation to physical examination, pathophysiology, inpatient care, and office management of patients.

Each program lasts for 10 weeks. A stipend of $850 is paid, and the hospital provides room and board or the financial equivalent. Administrative expenses at the outset (1969) for the development of programs, recruitment and matching of students, and evaluation were provided by ISMS, the Illinois Hospital Association and the Illinois Academy of General Practice. ISMS and participating hospitals have subsequently shared the expenses.

To participate it is strongly suggested that hospitals be those without a university affiliation or medical students in regular clerkships. This encourages selection of hospitals in communities without medical schools, and also those in rural settings.

All participants for the years 1969, 1970, and 1971 were sent a questionnaire. Of the 317 Illinois participants polled, 136 responded. The data presented are derived from their responses. The questions were intended to develop information about the impact of the project and to document career choices in this group.

## Survey Results

117 of the responders were male, 19 female. This pattern paralleled the sex distribution in applications, and has changed along with school enrollment patterns. The median age at the time of participation was 23 years, ranging from 20 to 31. All but 16 have currently active medical licenses, and some of the 16 are in government services.

Demographic data are displayed in Table 1. Most of those who participated in MECO did not come from a small town, and are not now in a small town. About half of the participants who provided requested data are now in a community smaller than their home town. This does not mean they have moved away from an urban setting however, as many of these students left a very big city, such as New York, for a smaller

DAVID M. ROXE, M.D., is an assistant professor of medicine at Northwestern University Medical School. He is an attending physician at both Northwestern Memorial and the Chicago Veterans Administration Research Hospital. Dr. Roxe is a diplomate of the National Board of Medical Examiners and the American Board of Internal Medicine, and a Fellow of the American College of Surgeons. He serves on the ISMS Council on Education and Manpower, as chairman of the ISMS Advisory Committee to Medical Students and as an examiner for the Illinois Council on Continuing Medical Education.

**Table 1**
**Available Population Data**

| | Hometown | Present Location |
|---|---|---|
| 0- 5,000 | 7 | 6 |
| 5,000-10,000 | 14 | 11 |
| 10,000-20,000 | 12 | 8 |
| 20,000-40,000 | 12 | 10 |
| over 40,000 | 87 | 96 |

**Table 2**
**Impact of MECO upon the Student**

| | Yes | No |
|---|---|---|
| Influential in Shaping Career | 82 | 52 |
| Respected and Valued by Hospital | 133 | 3 equivocal |
| Valued by Community | 86 | 46 |
| Return to Similar Setting | 83 | 47 |

big city, such as Chicago. It is noteworthy, however, that two-thirds of those students with a rural MECO experience are now located in communities of less than 40,000.

Table 2 indicates that 60% of students felt, in retrospect, that their MECO experiences had an influence on career choice. Written comments frequently stated that this was the most positive and gratifying event in the first 2 years of medical school. One physician, who later entered family practice, wrote: "It helped me understand medicine in the community hospital and within the community rather than that in the university setting." Another volunteered that the experience was "quite good in introducing a 'big city boy' to the smaller community" and helping him to realize that "medicine there is just as rewarding." The participants were overwhelmingly appreciative of the respect and consideration shown them by physicians and others at sponsoring hospitals. They were somewhat more critical of the community. Students in urban hospitals had difficulty identifying a community to which they could relate. Others, in rural area programs, indicated that after an official welcome, feature article in a local newspaper, and perhaps lunch with a civic group, the community seemed unaware and uninterested. One, who wrote a lengthy note, said that he and the community got along well and seemed to have a real interest in one another for three years, after which his letters and Christmas cards were simply unanswered. He remarked that he would still like to know why. A majority of the participants reported that they would be willing to return to a setting similar to that of their MECO project. Of those who would not, some learned that small towns did not suit them or their spouses, or had elected a career choice such as academic medicine, which excluded small towns.

The career choice of the 136 responders (Table 3) shows that a cluster of 72 (53%) selected internal medicine, family practice, general surgery or pediatrics. Only 18 (including oncology) selected subspecialization in medicine, and only 16 (including ophthalmology and orthopedics) elected to subspecialize in surgery. Nonetheless, the 53% of MECO participants who chose primary care areas is indistinguishable from the 53% of all Illinois graduates who made a similar choice.[2] Participation in MECO did not appear to alter patterns of career choice apparent in all graduates for a comparable period.

When asked to specify the type of career projected for themselves virtually the entire group volunteered one or more possibilities. This is notable because 67 responders were not yet in practice at the time of follow-up, which averaged seven years after MECO participation. Most of the 67 were training but six were serving in the military and one in the Indian Health Service. The results of the entire group show that 96 are committed to private practice, 25 to academic medicine and 10 undecided. (Five of the responses were indecipherable.) Most did not specify the type of community preferred. An urban setting was definitely required by 26, while 21 were equally definite in a preference for a rural or small town milieu. The others did not specify where their practice would be, but what *kind* of practice they wanted.

When asked to describe negative aspects of the MECO experience 81 replied that there were none, 15 noted poor organization, eight cited inadequate teaching and supervision, nine complained of non-participation by physicians and six found the exposure inappropriate for their level of education.

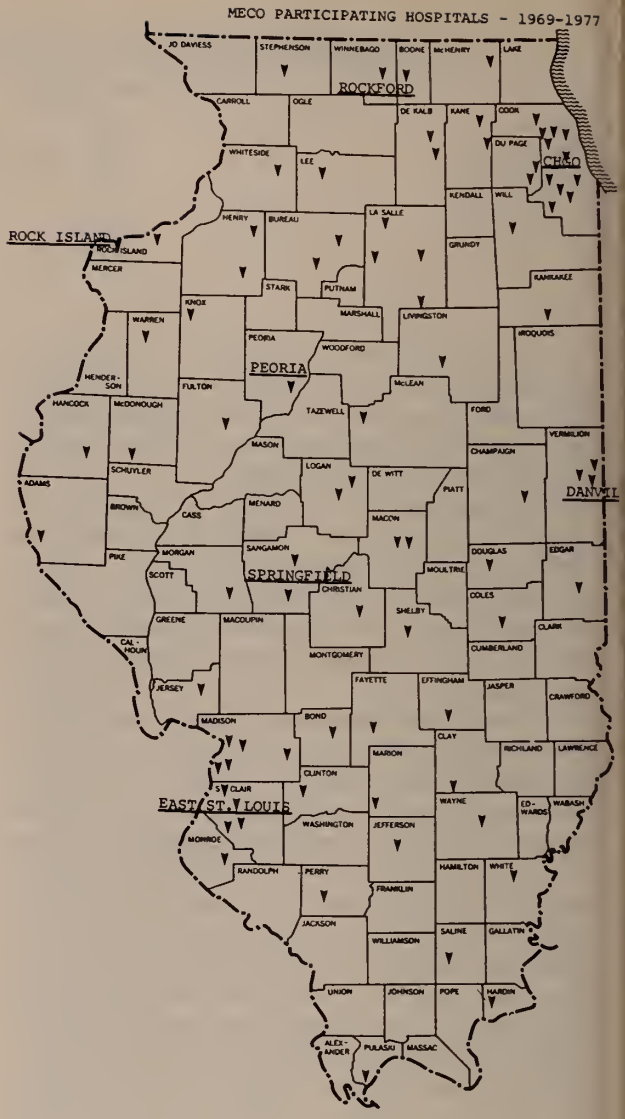
Questionnaires were also sent to 54 participating hospitals to sample their interests in the MECO project. The distribution of hospitals is shown on a map of Illinois (Figure 1). Of the 23 respondees, 11 indicated that they planned to continue in the program. Table 4 shows the reasons for non-participation. It also shows that five communities have already had a physician return to practice and 10 others have had requests to return from one or more of their

**Table 3**
**Career Choice of Participants in Illinois MECO Compared to All Illinois Graduates**

| | No. | MECO % | All Illinois |
|---|---|---|---|
| Internal Medicine | 24 | 17.6 | 25.4 |
| Family Practice | 21 | 15.4 | 8.5 |
| General Surgery | 11 | 8.1 | 11.6 |
| Psychiatry | 11 | 8.1 | |
| Ob-Gyn | 9 | 6.6 | 3.5 |
| Pediatrics | 7 | 5.1 | 4.3 |
| Orthopedics | 5 | | |
| Radiology | 5 | | |
| Emergency Medicine | 4 | | |
| Oncology | 4 | | |
| Ophthalmology | 4 | | |
| Other Medical Subspecialty | 14 | 10.3 | 8.8 |
| Other Surgical Subspecialty | 7 | 5.1 | 11.0 |
| Other Pediatric Subspecialty | 2 | | |
| Other | 8 | | |
| | 136 | | |

**Table 4**
**Hospital Responses**

| | |
|---|---|
| Hospitals Responding | 23 |
| Presently Participating | 11 |
| Reasons for Non-Participation | |
| a) Financial | 1 |
| b) Medical school ties | 6 |
| c) Students below expectations | 2 |
| d) No benefit to sponsors | 3 |
| Student Return to Practice in Community | |
| Definite | 5 |
| Probable | 10 |




MECO students. It is clear from the map that certain areas of physician-poor rural Illinois did not sponsor a single medical student.

## Discussion

One of the striking points of this follow-up of students who participated in MECO an average of seven years ago was that 49% of them were still in training. It is obviously necessary to have a long follow-up period to determine the end result of an experience during pre-clinical years in school. It is also apparent that once the contact is established a community has a number of years to develop and strengthen ties with prospective physicians.

The initial impact of the program upon medical students is very positive. In all but three cases the students were treated as respected and valued individuals. The contacts with physicians, hospital administrators, and community members were remembered warmly, and time and again respondees volunteered that this experience built their confidence and gave them good preparation for their clinical years.

There is no evidence that participation in the project brought a measurable increase in the percent of students selecting primary care rather than specialization, so that aspect of physician distribution was not affected. Seven years after their experience, more than 60% of participants still stated that they would happily return to "the same or a similar" setting for their practice, which suggests that geographic distribution could be affected by MECO participation.

Fifteen sponsoring hospitals already have definite or probable commitments from participants to practice in the sponsoring community. This may under-estimate the actual members,

as less than half of the hospitals responded to the questionnaire.

We are not aware of a single hospital or community that has established a formal follow-up and recruitment effort. It is clear that communities would have five years or more to strengthen an association begun by MECO participation. It would appear from our survey that recruitment efforts by the sponsors would be fruitful. A drawback, of course, is that the community might not get the desired physician specialty, *i.e.,* their student may choose hematology rather than OB-GYN. Such a result might encourage sharing of physician services among communities and development of area-wide programs to bring doctors and patients together. Nonetheless, it seems possible that any increase in the number of physicians and specialties available in a doctor-poor area will tend to make that area more attractive to other physicians, thereby facilitating recruitment. It is also clear that communities have not pursued this. Many doctor-poor areas have not participated at all. Those that have do not appear to have follow-up programs. Several of the responding participants (physicians) commented that their community seemed to lose interest in them after their 10 week MECO experience. The reasons for this disinterest are not determinable from our data.

To conclude, the MECO experience is highly regarded by participating medical students, and is influential in their career planning in a majority of cases. It leaves them disposed to return to a similar setting for their practice years, so that physician distribution could be affected by this experience. There is no evidence that MECO experience alters the percent of physicians entering primary care. Some physician-poor areas have not chosen to participate in MECO, and participating communities have not developed programs to maintain and strengthen relationships with future physicians. The reasons for community non-involvement are not apparent. ◄

**References**


1. Illinois State Medical Society and American Medical Student Association: MECO Project Description, page 1, 1970.
2. Center for Health Service Research and Development, American Medical Association: Medical School Alumni, pp. 143-148, 478-484.



★

*Specialized Service*

IN

PROFESSIONAL LIABILITY INSURANCE

*is a high mark of distinction*

THE

MEDICAL PROTECTIVE COMPANY

FORT WAYNE, INDIANA

*Professional Protection Exclusively since 1899*

CHICAGO AREA OFFICE:

T. J. Pandak, J. C. Kunches, L. R. Gannon, and W. G. Prangle, Representatives

814 Commerce Drive, Suite 101B, Oak Brook, Illinois 60521 (312) 325-7314

SPRINGFIELD OFFICE: W. J. Nattermann, Representative

426½ South Fifth Street, Springfield 62701 (217) 544-2251



# Seminars In Immunopathology and Oncology

Richard J. Ablin, Ph.D., Contributing Editor

# *Some Immunopathologic Aspects of Renal Disease*

By Elizabeth V. Potter, M.D./Chicago

During the past 15 years, immunologic reactions have been recognized as pathogenetic factors in an increasing number of diseases. Relatively early recognition of these factors in renal diseases was made possible by the development of renal biopsy and immunohistologic techniques. The biopsy allowed examination of renal tissue when the disease was acute and active rather than only after death when non-specific changes of chronic disease had developed. Examination of this tissue with fluorescein-tagged antisera revealed the presence or absence of immunoglobulins, complement components and, in some cases, specific antigens. Electron microscopy, also developed during this period, provided more precise localization of these materials. The role of immunologic factors in respective renal diseases was further elucidated by induction of similar diseases in animals through injection of antigens, antibodies, or complexes of both. Such clinical and experimental observations have defined two main classes of glomerulonephritis (GN): (1) immune complex diseases, in which deposits of antigen, antibody, and complement are found; and (2) antibasement membrane diseases, in which antibody is deposited on or in the glomerular basement membranes, the latter serving as the antigen. Both types of glomerulonephritis had been produced in animals before biopsy and immunohistologic techniques were available to define and relate the experimental and human diseases. Presently such correlation has been achieved and permits classification of renal diseases according to their immunopathology.

ELIZABETH V. POTTER, M.D., is offiliated with McGow-Northwestern University Medical Center in Chicago. Doctor Potter is on ossociate professor in the Deportment of Medicine, Sectian of Nephrology and Hypertension.



## Classification of Renal Diseases by Immunohistologic Observations

*Category One: Acute Immune Complex Diseases with Subepithelial Deposits on Glomerular Basement Membranes*

Early workers[1-3] injected rabbits with foreign serum or specific serum proteins and observed that some animals developed proteinuria, low serum complement and proliferative GN shortly before free antibody appeared in the serum. This evidence of GN was transient in all animals. It was thought analagous to serum sickness in patients treated with one or a few injections of

hyperimmune heterologous antiserum to combat bacterial infections. Subsequent application of immunologic techniques to studies of animals injected with bovine serum albumin (BSA)[4-6] showed that deposits of BSA, host gamma globulin and the third component of complement ($C_3$) as represented by β1C/β1A globulins (β1C) were scattered throughout all glomeruli on the subepithelial aspect of the capillary basement membranes. When applied to human renal biopsies, these techniques showed similar deposits of host gamma globulin and/or β1C in the glomeruli of patients with poststreptococcal acute glomerulonephritis,[7,8] secondary syphilis,[9,10] bacterial endocarditis,[11,12] viral hepatitis,[13] and Hodgkin's disease.[14,15] Specific antigens have been more difficult to demonstrate in the human lesions, perhaps because they have been masked, altered, or destroyed before biopsy. Fibrinogen or related products (F) has been described diffusely within endothelial and mesangial cells of poststreptococcal acute GN in contrast to the other lesions.

*Category Two: Chronic Immune Complex Diseases with Subepithelial Deposits on Glomerular Basement Membranes*

Dixon *et al*[16] further demonstrated that only a few animals developed acute GN after receiving BSA because only those few produced just enough antibody to result in the moderate excess of antigen which favors formation of soluble immune complexes. Animals that produced little or no antibody did not become ill, nor did those that produced large amounts of antibody and rapidly eliminated the antigen as less soluble immune complexes by way of the reticuloendothelial system. However, when all animals were maintained in slight antigen excess by repeated injection of proper amounts of antigen for each, all animals developed chronic GN. Deposits of antigen, host gamma globulin and complement were found deposited almost continuously along the epithelial aspect of the glomerular capillary basement membranes. This is analogous to the human lesion of membranous GN in which deposits of host immunoglobulin and complement are found in the same location. Unfortunately, the antigen is not known in most cases of human membranous GN. However, in a few instances specific antigens have been suspected and demonstrated. These include malarial antigen in 3/13 nephrotic patients with malaria;[17] tubular epithelial cell antigen in a case of renal vein thrombosis[18] and in a nephrotic patient with sickle cell disease.[19] Tubular damage in the latter cases apparently results in release of this antigen with subsequent formation of auto-antibody and circulating immune complexes. Carcino-embryonic antigen in a nephrotic patient with colonic carcinoma[20] and erythocyte stromal antigen in a patient with erythrocyte-autosensitization syndrome have also been demonstrated.[21] F (fibrinogen or its derivatives) has been demonstrated only irregularly in these lesions.

*Category Three: Immune Complex Diseases with Subendothelial Deposits on Glomerular Basement Membranes*

In other lesions, immunoglobulins and complement have been deposited on the endothelial aspect of the glomerular basement membranes. Most of the deposits in active lupus erythematosus (LE) GN are located here and may be massive while other deposits are located on the epithelial side of the basement membranes. The antibody in these deposits has been shown to react with DNA, and DNA has been identified in the deposits.[22] (In less active lupus lesions, deposits are limited to the mesangium or, rarely, are similar to those of membranous GN or anti-basement-membrane GN.[23]) In the majority of patients with membranoproliferative GN (type 1) deposits containing β1C or β1C and IgG or IgM are located subendothelially in all glomeruli.[24,25] Hydrocephalic patients with infected ventriculocaval shunts have developed GN with very similar renal lesions.[26] In cryoglobulinemia, massive endomembranous deposits of the proteins present in the cryoglobulins may be present focally.[27] Massive focal deposits of IgM and β1C also are present subendothelially in focal glomerular sclerosis.[24,28] F has been observed only irregularly or focally in the above lesions.

*Category Four: Immune Complex Diseases with Deposits in Glomerular Basement Membranes*

Electron dense deposits containing β1C have been described[24,29,30] within the glomerular basement membrances of 20% to 50% of patients with membranoproliferative lesions by light microscopy (type 2 disease). β1C always is decreased in the serum of these patients and an activator of β1C is present in the serum and referred to as "nephritic factor." F has been observed within Bowman's space and in crescents in this syndrome. The absence of immune globulins in the deposits suggests that they are not immune complexes.

The electron dense deposits originally located on the epithelial aspect of the basement membranes in membranous GN may become intra-

**Table I**
**Correlation of Immunofluorescent Observations With Clinical Diagnoses**

| Brightest Glomerular Stain For | General Pattern of Stain | Relation to Basement Membranes | Other Stain | Most Probable Diagnosis |
|---|---|---|---|---|
| IgG | scattered granular deposits in capillary loops and mesangium, diffuse | subepithelial | + {βIC, F} | acute GN[a] |
| | continuous granular deposits in capillary loops, diffuse | subepithelial | ± βIC | membranous GN |
| | continuous granular deposits in capillary loops and mesangium | {subendothelial, subepithelial} | ± βIC | lupus GN active |
| | smooth linear deposition in capillary loops | subendothelial | ± βIC | RPGN[b] |
| | granular deposits in mesangium only, diffuse | | ± {βIC, IgM, IgA} | lupus GN very mild |
| IgA | granular deposits in mesangium only, diffuse | | ± {IgG, IgM, βIC} | IgA disease |
| | granular deposits in mesangium only, diffuse | | + F | anaphylactoid purpura |
| IgM | smooth linear deposition in capillary loops, diffuse | subendothelial | ± βIC | rejection |
| | masses of deposit in peripheral capillary loops, focal | subendothelial | + βIC | focal glomerular sclerosis |
| βIC | scattered granular deposits in capillary loops, diffuse | subepithelial | ± IgG | acute GN |
| | continuous granular deposits in peripheral capillary loops, diffuse or focal | subendothelial<br>intramembranous | IgG<br>none | MPGN[c] type 1<br>MPGN type 2 |
| | masses of deposit in peripheral capillary loops, focal | subendothelial | + IgM | focal glomerular sclerosis |
| F | intracellular and/or thrombi | | none | HU[d] syndrome |
| | inatracellular and/or thrombi | | ± IgG | toxemia |
| | intraluminar thrombi | | ± IgG | TTP[e] or IC[f] |
| none | | | | minimal change disease |

[a]glomerulonephritis
[b]rapidly progressive glomerulonephritis
[c]membranproliferative GN
[d]hemolytic-uremic syndrome
[e]thrombotic thrombocytopenic purpura
[f]intravascular coagulopathy

membranous and subsequently lose their density as the disease regresses. These deposits are less likely to stain for βIC than the subepithelial deposits seen earlier in the disease although they still stain for IgG.[31]

*Category Five: Immune Complex Diseases with Deposits in the Mesangium*

Several investigators[32-34] have noted that when certain immune complexes or aggregates of gamma globulin (which resemble immune complexes in their pathophysiologic effects) are injected into animals they deposit mainly in the glomerular mesangium. Experimental evidence[34] also indicates that larger, less soluble complexes are preferentially located here and that they may spill over into capillary loops where the mesangium is saturated, producing focal inflammation and/or proliferation.[35] These experiments, as well as the natural history of human lesions, suggest that immune complexes in the mesangium cause little renal damage. Human lesions with deposits limited to the mesangium include cer-

**Table II**
**Correlation of Light Microscopy With Immunofluorescent Observations and Clinical Diagnosis**

| Description by Light Microscopy | | Immunofluorescent Pattern | Most Stain | Other Stain | Most Probable Diagnosis |
|---|---|---|---|---|---|
| diffuse | proliferative GN[a] | scattered granular deposits in all capillarly loops, subepithelial[b] | β1C or IgG | F | acute GN |
| | membranous GN | continuous granular deposits in all capillary loops, subepithelial | IgG | β1C | membranous GN |
| | membrano-proliferative GN | continuous granular deposits in peripheral capillary loops, subendothelial[b] | β1C | IgG | MPGN type 1 |
| | | intramembranous | β1C | none | MPGN type 2 |
| focal | proliferative GN | granular deposits in peripheral loops, focal | IgG | β1C F | focal GN embolic? |
| | | granular deposits in mesangium, diffuse; and in loops, focal | IgG | β1C IgA | lupus GN mild |
| | | granular deposits in mesangium, diffuse | IgA | IgG β1C | IgA disease |
| | | | IgA | F | anaphylactoid purpura |
| | sclerotic | massive subendothelial deposits in peripheral loops, focal | IgM β1C | none | focal sclerotic GN |
| normal glomeruli | | none or traces | | | minimal change disease |

[a]glomerulonephritis
[b]subepithelial and subendothelial distinguished on immunofluorescence by the lumpy pattern on external aspects of the stain in the former in contrast to a smooth external aspect in the subendothelial stain. Both confirmed by electron microscopy.

tain cases of microscopic hematuria which are characterized on light microscopy by focal proliferation (often mild) but by mesangial deposits of gamma globulins in all glomeruli on immunofluorescent microscopy. When these deposits are brightest for IgA and also stain for IgG with or without IgM and β1C, the lesion probably represents IgA (Berger's) disease.[36] This has been observed more often in France than in the United States.[24,37] Mesangial deposits of IgG with or without IgA have been found in LE patients with minimal or no evidence of renal disease.[23] Although mesangial immune deposits are found in IgA disease and LE in the absence of renal dysfunction, some patients with IgA disease have gone on to glomerular obsolescence and renal failure six or more years after the onset of hematuria[38] while some LE patients with deposits limited to the mesangium have developed active lupus GN within two years of initial biopsy.[39] Thus, the prognosis for patients with purely mesangial deposits, while relatively good, may not be good in long-term analyses. Patients with anaphylactoid (Henoch-Schönlein) purpura also have focal lesions by light microscopy with diffuse mesangial deposition of IgA and lesser amounts of IgG and β1C by immunofluorescent microscopy.[40] In addition, however, these patients usually have substantial deposits of F which may contribute to the relative severity of their disease during active periods in contrast to the other patients with purely mesangial deposits of immunoglobulins.

*Category Six: Immune Complex Diseases with Deposits in the Tubules*

Although the majority of immune complexes have been described within glomeruli, in some cases they have been observed along the basement membranes of the tubules accompanied by clinical signs of tubular dysfunction. Such tubular deposits have followed experimental injection of kidney in adjuvant in animals,[41] and have been described in seven patients with a variety of renal diseases.[42] In addition, one patient receiving rifampin developed interstitial nephritis and tubular glycosuria with granular

deposition of gamma globulin and β1C in and around the tubular epithelial cells.[43] Granular deposits of gamma globulins are often seen focally within the tubular cells of patients with LE. However, these probably represent reabsorption of globulins rather than inmune deposits since they are within the cytoplasm of the cells rather than along the basement membranes.

*Category Seven: Anti-Basement Membrane Diseases*

In 1933, Masugi[44] injected rats and rabbits with heterologous antiserum to homologous kidney tissue and observed the development of progressive GN. When immunofluorescent techniques were applied to such experiments,[45] the nephrotoxic gamma globulin was found soon after its injection in a smooth, linear pattern along all glomerular basement membranes. This was accompanied by host β1C unless avian rather than mammalian anti-kidney serum had been employed. Several days later, host gamma globulin was also deposited along the basement membranes as antibody to the heterologous antiserum which had acted as an antigen. This second, or host antibody was accompanied by deposition of β1C whether or not avian nephrotoxic serum had been employed. Rapid progression to renal failure followed onset of the autologous phase of the immune response. Immunofluorescent observations on patients with Goodpasture's syndrome[46] and certain others with rapidly progressive GN in the absence of hemoptysis[47] have shown similar smooth linear stain for host gamma globulin. Antibody eluted from the glomeruli in such cases reacts with normal human glomerular basement membranes and pulmonary alveolar basement membranes.[46,47] Very small amounts of antibody also have been demonstrated in the serum of patients with rapidly progressive GN with or without hemoptysis and in larger amounts following removal of their kidneys.[47]

Similar linear deposition of gamma globulin has been observed in a very few patients with LE[23] and in several patients with diabetic glomerulosclerosis.[48] While the gamma globulin appears to be antibody in the patients with LE, there is no evidence that it is so in the diabetic patients. Indeed, unsuccessful attempts to elute gamma globulin with acid from the diabetic glomeruli suggest that this globulin represents non-immunological entrapment of protein in the diabetic glomerular basement membranes.[48]

In many instances of anti-basement membrane disease, the tubular basement membranes are also at least focally stained for gamma globulin, as some glomerular basement membrane antigens cross-react with tubular basement membrane antigens. However, in two studies[49,50] the second associated with methicillin, gamma globulin was present on tubular basement membranes and absent on glomerular basement membranes. When eluted in the first study, it was specific for tubular basement membranes. Both patients had interstitial nephritis with tubular dysfunction.

## The Significance of Immunohistologic Observations

Although the many immunologic factors probably involved in the pathogenesis of renal diseases continue to be studied both experimentally and in patients, their exact roles have not been elucidated in most cases. The factors include antigens, antibodies and immune complexes. Antigens may vary in molecular size, electric charge, and immunospecificity (including cross-reactions with other antigens and host tissues). Antibodies vary in class of immunoglobulin, molecular size, reactive valency, avidity for antigen, and amount produced. Immune complexes vary in degree of solubility according to the nature of respective antigen and antibody molecules plus the amounts of each present. Complexes of relatively small antigens and antibodies formed in slight antigen excess are sufficiently soluble to be localized in the glomeruli. Here they may fix and activate complement through the classical pathway involving $C_1$, $C_2$ and $C_4$ as well as $C_3$. $C_3$ also may be activated in the absence of immune complexes through alternate pathways which do not involve $C_1$, $C_2$ or $C_4$. This seems to have occurred in several cases of acute GN[51] as well as in membranoproliferative GN[25] where β1C is found in glomeruli without immunoglobulins and where serum $C_3$ is decreased in contrast to the earlier complement components. The activation of $C_3$ (which releases vasodilating and chemotactic factors and promotes phagocytosis with resulting release of lysozomal enzymes which, in turn, increase inflammation and damage basement membranes) would seem to be a key factor in most inflammatory nephritides. However, immune complex disease has been produced in animals that were depleted of[52] or congenitally deficient in[53] complement as easily as in normal animals. Furthermore, continued activation of $C_3$ by injections of zymosan has failed to induce renal disease in mice.[54] Thus, the im-

portance of complement activation in renal diseases continues to be assessed.

Despite these inconsistencies, correlation of experimental and clinical lesions through immunohistologic observations has increased our understanding of the etiology and pathophysiology of renal diseases to such a degree that such observations are now of practical value in diagnosis and management. Examination of renal biopsies with only five widely used and commercially available antisera (Meloy Laboratories, Springfield, Virginia) may provide within hours a very good diagnostic clue (Table I).

When IgG is brightest and β1C is also present in scattered, discreet deposits on the epithelial aspect of the glomerular basement membranes, acute immune complex disease is probably involved, most commonly as poststreptococcal acute GN. When similar deposits of IgG with or without β1C are present almost continuously along the glomerular basement membranes on the subepithelial aspects, chronic immune complex disease or membranous GN may be diagnosed. When irregular deposits of IgG, with or without β1C and other immunoglobulins are found on the endothelial and epithelial aspects of the glomerular basement membranes, active LE GN is a likely diagnosis. In contrast to all the above, smooth, linear deposition of IgG with or without β1C indicates anti-basement membrane disease unless the patient is diabetic. When IgG is brightest, but limited to the mesangium, minimal or early LE GN may be suspected.

When IgA is brightest, it usually is in the mesangium. If IgG, IgM and β1C also are present and fibrinogen is absent, IgA (Berger's) disease is indicated. When other immunoglobulins are absent, or present in only small amounts, but F is conspicuous, anaphylactoid purpura is a likely diagnosis.

IgM is not often the brightest stain observed unless the tissue is from transplanted kidney. In some cases of rejection, large thrombi stain brightly for IgM which also is in linear streaks in glomeruli. Brilliant focal masses of IgM and β1C are almost pathognomonic for focal glomerular sclerosis.

β1C may be the brightest stain in the scattered deposits found in certain cases of acute immune complex disease, usually poststreptococcal. It is also conspicuous in membranoproliferative GN as it is the only stain in type 2, accompanied by IgG in type 1, and mainly limited to the periphery of glomerular tufts in a lobular pattern in both types.

When F is the brightest stain observed and this appears diffusely within the endothelial and mesangial cells with or without thrombi in small vessels, hemolytic-uremic syndrome or toxemia may be suspected. The presence of thrombi in the absence of most other stains suggests thrombotic thrombocytopenic purpura or an intravascular coagulopathy. Bright stain for F within Bowman's space is characteristic of exudative GN with crescent formation. It is most impressive in antibasement membrane diseases but also present in some acute or membranoproliferative GN.

When there is no stain (or only nondescript traces of stain for immunoglobulins or F) in tissue from patients with the nephrotic syndrome, the diagnosis is probably minimal change GN. However, a focal GN cannot be excluded by examination of a few glomruli, particularly in focal glomerular sclerosis, which seems to be limited to the cortico-medullary glomeruli early in the disease.

Immunofluorescent observations also may be interpreted in view of the diagnosis by light microscopy when available, as indicated in Table II.

Appropriate management is facilitated by the information obtained through the above observations. If there is evidence of acute immune complex disease, the source of antigen should be eradicated and the outlook is good. If there is evidence of chronic immune complex disease, the antigen should be eradicated. When this is not known, as in most cases, or cannot be eradicated, as in LE, treatment with steroids, immunosuppressive drugs, or plasmaphoresis may be beneficial. When the absence of any immunological stain in patients with nephrotic syndrome suggests minimal lesion GN, the prognosis is good, with or without steroid treatment. Evidence of glomerular sclerosis, membranoproliferative GN or antibasement membrane disease signifies a poor prognosis despite treatment. ◄


### Acknowledgement

Support for this work was received from National Institutes of Health Grant AM 05614 and the Otho S. A. Sprague Memorial Institute.


### References

A complete list of references for "Some Immunologic Aspects of Renal Disease," may be obtained by writing the *Illinois Medical Journal*, 55 E. Monroe, Suite 3510, Chicago 60603.

# Attacking the Cost Crisis

*The ISMS-sponsored Task Force on Cost Effectiveness was created to identify and ameliorate the causes of spiralling health costs in Illinois. Represented on the Task Force are ISMS, Blue Cross/Blue Shield, Illinois Hospital Association, Illinois Clinic Managers Association, Chicago Hospital Council and Chicago Medical Society.*

*The following articles—developed at the request of the Task Force—outline a number of practical suggestions for containing costs. They are intended to focus attention on the issues and stimulate your participation in Task Force efforts. A periodic series of articles to be featured in* IMJ *will illustrate specific suggestions for holding down costs.*

*If you have initiated successful cost-saving measures in your practice, outline them in a short article (500 word maximum) and submit it—along with a personal photograph—for possible publication in* IMJ. *Later this year the Task Force may reprint these articles and others in booklet form to assist in development of individual or area-wide cost containment programs.*

*Please note that views expressed in these articles are those of the author, and are not intended to reflect official positions of any organization represented on the Task Force.*

## Things We Have Done—Or Should Do

By L. S. Doyle/Galesburg

Every organization—manufacturing, commercial or professional—has a certain amount of "fat" in its cost of operation. Some businesses can afford to be careless about their expenditures, medicine among them, to some degree. Now, with third party intervention rapidly approaching, this luxury won't be available to health care dispensers. When we can no longer raise our fees to cover the inevitable cost increases, what can we do? If we want to maintain an income level we must find ways to take the "fat" out of our expenditures.

Cost saving in any organization is a state of mind. The involvement and cooperation of everyone from doctor to janitor is essential to any cost containment campaign. It's not a simple annual review, but a constant effort.

L. S. DOYLE is the administrator for The Golesburg Clinic in Golesburg, Illinois.



The following are a few ideas we have either implemented or plan to attempt.

**Personnel**

*Overtime:* Don't let people abuse it, but on the other hand don't be afraid of it. Within reason, it's better to pay overtime than to hire part-time help. New employees create a lot of hidden costs—training and fringe benefits among them.

*Unions:* The threat is ever-present and potentially very expensive. Do everything you should do to make union membership unattractive to your people.

*Time Utilization:* Don't pay R.N.'s to do aides' work. Pay your employees on an hourly basis and if possible have them work only when needed. Many prefer it that way.

*Terminations:* Hire only on a probationary basis. If not satisfied, terminate immediately. The longer you wait to terminate the harder and more expensive it is.

**Space**

*Energy:* Expensive and going to be more so. A professional survey can be very worthwhile. It paid off for our clinic.

*Telephones:* Do you really need all the extensions you have? Watch the toll charges—you may have some personal calls on your bill. If your toll volume is large, an outward WATTS line may save.

*Building Maintenance:* Ask your regular employees to take care of their own areas—desks, counter tops, examining room desks and tables. This will save on janitorial costs.

**Other**

*Professional Journal Subscriptions:* You probably have many duplications. You might consider buying one subscription for your library. On receipt of a new issue, copy the table of contents and circulate to staff. They can let you know which articles they want to read. You copy those articles and return to them.

*Budgets:* A valuable tool for keeping track of where you are and where you're going, even in small offices. We involve our supervisors in the budgeting process and give them monthly reports on their departments. It helps.

*Checking vs. Savings Accounts:* It pays to watch your balance in non-interest bearing checking accounts. Banks and Savings & Loans now permit and even encourage your having both checking and savings accounts. They allow switching cash back and forth. The daily interest from the savings account really mounts up.

There are literally dozens of ways of containing your costs. Mostly they're common sense things that we can all devise with some thought. That's the key—think about saving and encourage everyone in your organization to do likewise.

# The Long Range Solution to Cost Containment

By Richard C. Shaw, M.D./Chicago

I am encouraged by the articles in the February issue of the *Illinois Medical Journal* which center on the containment of health care costs.

Certainly, there are a variety of ways to lower the unit cost of medical services and decrease the use of high cost facilities that deliver quality care. The practical application of these techniques should be encouraged and pursued.

Yet I believe that the ultimate answer to the high cost of health care delivery is to reduce the need for medical care. If the professional medical community begins to practice, as well as advocate, positive lifestyle changes, there would be a far greater reduction in the overall cost than the more publicized short-term cost containment efforts can bring.

The term, "improved lifestyle," is getting more and more attention, but so far there has been little evidence of change. Despite repeated warnings that smoking, drinking, improper diet, prolonged anxiety (undue stress), and, at best, sporadic exercise do increase the chances of illness, most people are still reluctant to give up these habits.

The problem is motivation. Few would argue that the public has not been sufficiently exposed to warnings about these potential health hazards, but exposure to these warnings does not always bring learning. Exposure is not education. Education implies that a person has been sufficiently stimulated or motivated to learn a new set of skills or habits. In this case, good health habits.

Last year, we at the Chicago-based Blue Cross and Blue Shield Plan began to work with our membership on a variety of community programs designed to heighten public awareness of personal health problems and to provide guidance toward solving those problems. We believe that these educational efforts can contribute to better health and, consequently, help to lower the overall cost of health care.

In a broader sense, we physicians are in the best position to not only help educate the public, but more importantly, to motivate them. Perhaps our most useful tool in this cost containment effort is the inherent trust in our patient relationships. Through this bond we can convince people that it is to their advantage to

RICHARD C. SHAW, M.D., is vice president and medicol director of Illinois Blue Cross ond Blue Shield Corporation.



modify their lifestyles, but our credibility is lost if we, too, are offenders. If we are fat, if we smoke, if we don't partake in vigorous regular conditioning exercise, if we cannot advise with conviction about proper diet and how to avoid stress, then our exhortations will go unheeded. If we, who represent concern for the health of the nation, don't practice good health habits, who can be expected to take the lead?

Take a hard look at your own lifestyle. Can it be modified? If so, adjust it accordingly and then use your influence to convince your patients to take their own lifestyles seriously. It can improve their quality of life and, hopefully, reduce their need for medical care in the future. Preventive health maintenance is the long-term solution to cost containment.

# The Administrator's Perspective

By George Maroney/Carbondale

Today it is quite popular to document and publicize the savings affected in our hospitals to demonstrate our efforts as administrators to reduce hospitalization costs. I would hate to think that economies affected today would not have come to pass if Mr. Califano had not publicly implied administrative inefficacy in our hospitals.

Regardless of pressure from the government or any other source, successful administration requires an economical, cost effective picture. If an administrator fails to do that, his institution will falter and he will fail. This form of cost effectiveness includes the administrator's negotiations for the most economical insurance coverage—possibly self insurance, group purchasing plans—effective personnel utilization, effective energy cost monitoring and the many other items that go into the operation of a hospital. Much can be done in these areas; it is being done and is routinely achieved.

One area in the hospital scheme is more difficult to manage and can carry a tremendous price tag. This element, which might be termed ambition, is one that all federal and state planning and regulatory agencies may find themselves unable to control. I refer to those ambitions of a board of trustees, of an administrator, and of physicians, all of whose natural conservatism and frugality sometimes dissipate within the hallways of a hospital. There is great talk of planning efforts, avoidance of duplication of services and multi-institutional agreements. Many of us will publicly laud these worthwhile goals. Privately, the value of these goals is respected only to the extent that they do not affect our particular institution and inhibit the growth of our hospital.

Now, for a moment, let's examine the practical scene. Our efforts in cost control must exceed the theoretical. Each of us must pay his own way each day. We at Memorial have just concluded review of an interconnect plan which will halve our monthly telephone costs (from approximately $3500 to $1600). Another practical point to consider is the long-standing popularity of contracting with firms for such services as housekeeping, dietary and security. I think each of us needs to examine and evaluate the merits of paying a profit margin to external agencies assuming these duties. We, as administrators, must accept our responsibility to maximize efficient utilization of personnel and alternative means to deliver each routine service.

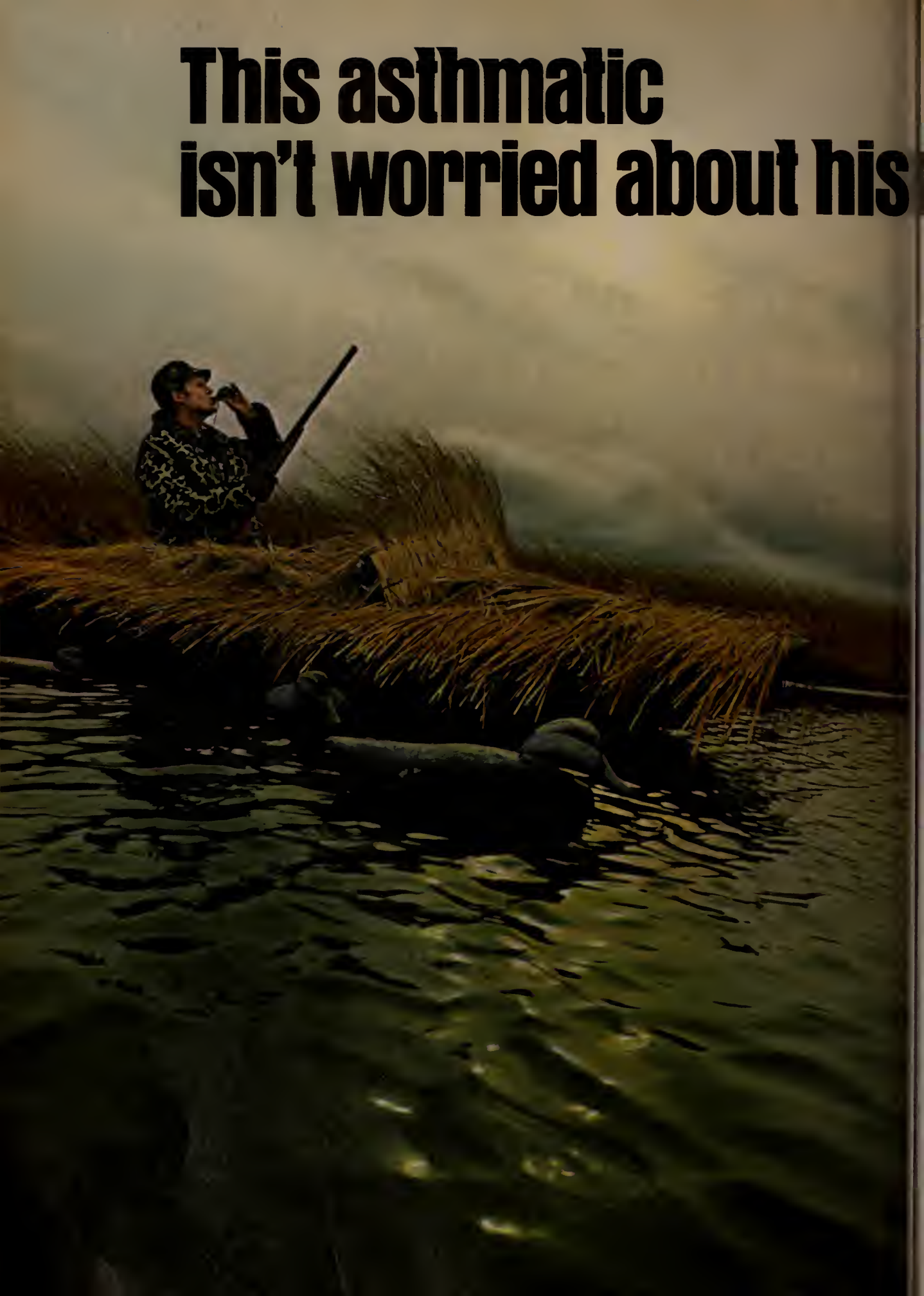
Growth must be allowed, but it must be responsible growth that meets the needs of our respective communities and is not conceived in a vacuum by over-zealous administrators, physicians and boards. Many of the things we may want for an institution and many of the things that we are capable of doing are simply not appropriate in every instance. Everything learned in a residency cannot be continued in a practice. Our personal ambitions and the ambitions of an institution must be controlled by us, not by one of Mr. Califano's boring formulas. If we cannot control some of our own lusts, we deserve him as our bedfellow.

GEORGE MARONEY is administrator of the Memorial Haspital of Corbondale.




COLACE prevents hard, dry stools common to constipation . . . and does it without laxative stimulation. COLACE assists peristalsis by simply letting intestinal water permeate stools.
COLACE helps to prevent painful straining at stool—particularly important in patients with delicate anorectal disorders. Safe and non-habit forming . . . COLACE, the simple water way to ease constipation from infancy to old age.
Simple drops of water help make COLACE® the most widely used stool softener.
COLACE®
dioctyl sodium sulfosuccinate
Mead Johnson
PHARMACEUTICAL DIVISION

# This asthmatic isn't worried about his



# next breath...

## he's active
## he's effectively
## maintained on

# QUIBRON®

Each capsule or tablespoonful (15 ml) elixir contains theophylline (anhydrous) 150 mg and glyceryl guaiacolate (guaifenesin) 90 mg. Elixir: alcohol 15%

### high theophylline for effective around-the-clock therapy

Quibron may give the asthmatic up to eight hours of bronchodilation with each dose and provides the high dosages of theophylline which are now believed necessary to keep patients free of acute attacks and chronic wheezing.

### 100% free theophylline

Quibron helps achieve high serum theophylline levels with minimal dosage volume...delivers 100% free theophylline in comparison to many other compounds which contain from 47% to 91% effective theophylline.

### individualized theophylline dosage schedule

Today's more efficient usage of theophylline includes individualizing dosage and monitoring serum theophylline levels. The usual recommended dosages of Quibron are: Adults—1 to 2 capsules or tablespoonfuls every 6 to 8 hours; dosage may be cautiously adjusted upward when necessary to a maximum of 2000 mg theophylline per 24 hours. Children under 12—4 to 6 mg theophylline per kg/body weight every 6 to 8 hours; dosage may be cautiously adjusted up to 9 or 10 mg/kg every 6 hours.

Now, for the asthmatic who requires high-dose theophylline therapy for therapeutic serum concentrations

Mead Johnson Pharmaceutical Division announces

# QUIBRON®-300

Each capsule contains 300 mg theophylline (anhydrous) and 180 mg glyceryl guaiacolate (guaifenesin)

For Brief Summary, please see the last page of this advertisement.

# QUIBRON®-300

Each capsule contains 300 mg theophylline (anhydrous) and 180 mg glyceryl guaiacolate (guaifenesin)

## The new high-dose theophylline capsule... for dependable theophylline therapy when products of lower dosage do not adequately control asthma symptoms.

## Specially formulated

### ...for optimal efficacy

Quibron-300 is appropriate therapy for asthma patients whose symptams are nat adequately controlled on lower doses of theophylline, particularly for patients whase theophylline dosage has been adjusted upward to achieve therapeutic serum levels. In one study,[1] an average peak increase in $FEV_1$ of 35% was demonstrated after a single dose equivalent ta one Quibran-300 capsule, and significant improvement in this pulmonary function lasted for nearly eight hours after administration.

### ...for optimal predictability

One Quibran-300 capsule q6-8h yields therapeutic serum levels (10-20 mcg/ml) in many adults. With a single dose, more than 75% of patients achieved serum levels potentially providing clinical benefit (5-15 mcg/ml). Half-life of theophylline varies widely from patient to patient, making monitoring of theophylline therapy impartant. Patient response may be monitored clinically if blood levels are not available as lang as dosage does not exceed 1200 mg in 24 hours for adults.

### ...for optimal dosage convenience

The simple, convenient dosage of new Quibran-300—one capsule every six ta eight hours—makes it easy far patients to comply with high-dase regimens aften required ta achieve therapeutic serum levels. Quibran-300 capsules may pravide maximum therapeutic value with maximum canvenience. In fact, the switch from a low-dase to a high-dose regimen may be accomplished by merely switching capsules, by stepping up to Quibron-300 capsules.

### ...for minimal theophylline side effects

Adverse reactions ta theaphylline are related ta serum levels and are usually not a prablem at concentratians belaw 20 mcg/ml. Of 45 patients studied[1] after a single dase, only seven reported adverse reactians. The most cammon reactian was a feeling of lightheadedness by three of these seven patients.

**Reference** 1. Data an file. Mead Jahnsan Pharmaceutical Division.

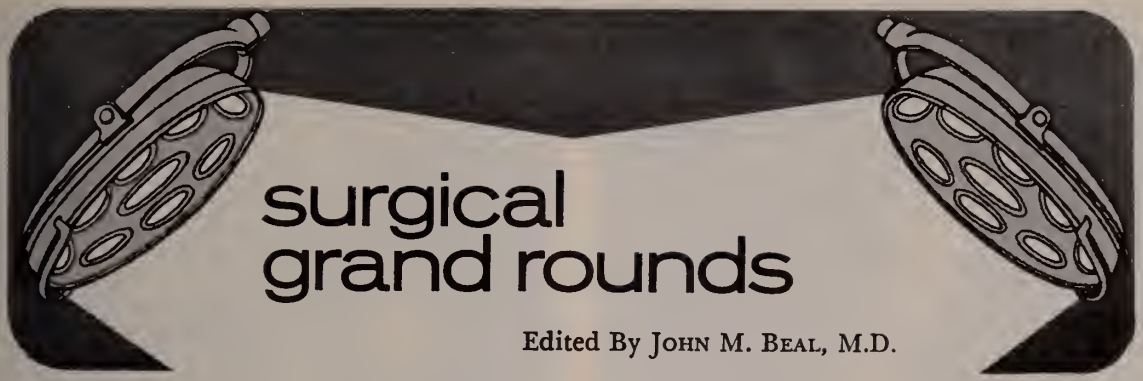
---

**Indicatians:** Far the symptamatic treatment of branchaspastic conditions such as bronchial asthma, asthmatic branchitis, chronic bronchitis, and pulmonary emphysema.
**Dosage: Quibran**—Adults: 1-2 capsules ar 1-2 tablespaanfuls elixir every 6-8 haurs. Children under 12: 4-6 mg theaphylline/kg body weight every 6-8 hours.
**Quibran-300**— Adults: 1 capsule every 6-8 haurs.
Theaphylline dosage may be cautiously increased ta 2000 mg/24 haur in adults and 9 ar 10 mg/kg every 6 hours in children. Manitaring af serum theaphylline levels at higher dosages is recammended.
**Precautians:** Da nat administer mare frequently than every 6 hours, or within 12 hours after rectal dose of any preparatian containing theophylline or aminaphylline. Do not give ather xanthine derivatives concurrently. Use in case of pregnancy anly when clearly needed.
**Adverse Reactians:** Theaphylline may exert same stimulating effect an the central nervous system. Its administratian may cause local irritation of the gastric mucosa, with possible gastric discomfart, nausea, and vamiting. The frequency of adverse reactions is related ta the serum theophylline level and is nat usually a problem at serum theaphylline levels below 20 μg/ml.
**How Supplied:** Quibran Elixir: Battles of 1 pint and 1 gallon. Quibran Capsules: Battles of 100 and 1000 and unit-dase packs of 100. Quibron-300 Capsules: Bottles af 100.

Mead Johnson PHARMACEUTICAL DIVISION

© 1978 Mead Johnson & Company • Evansville, Indiana 47721 U S A

MJL 7-4280




Edited By John M. Beal, M.D.

*Surgical Grand Rounds are held weekly on Tuesday at 5:00 p.m. in the Offield Auditorium of the Passavant Pavilion of Northwestern Memorial Hospital. Patient presentations from Northwestern Memorial Hospital and the Veterans Administration Lakeside Hospital form the basis of the discussions. This case report was part of the Surgical Grand Rounds of January 4, 1977.*

## *Case Report*

# Iatrogenic Injury of the Brachial Artery

**Dr. Joseph Gavron:** A 37-year-old woman was admitted with end-stage renal disease which had begun four years earlier as glomerulonephritis. She is treated now by hemodialysis every third day. At a California satellite dialysis unit she had noted some pain and tenderness when a 13 gauge dialysis catheter was inserted in her antecubital space. The technician had adjusted the needle and noted swelling and extravasation of blood. Dialysis was stopped and the hematoma was treated at that time with pressure. The patient was sent home, but the hematoma in the antecubital fossa continued to enlarge. This was not considered serious because the usual thrill was plapable along the venous side of the arterial venous fistula created for dialysis in her left arm. A routine chest X-ray several weeks later revealed that the cardiac silhouette seemed to have been increased in size. She was referred to Northwestern Memorial Hospital.

When admitted, she complained only of the presence of the mass in her left arm which had enlarged somewhat. There was a palpable thrill over the mass, as there was down the venous side of the fistula in the left arm. The only cardiac abnormality was a long-standing systolic ejection murmur. Her physical examination was otherwise unremarkable.

### Second Case Report

The second patient had a similar problem. A 68-year-old attorney was a long-term dialysis outpatient. While in our dialysis unit receiving blood after his dialysis, he noted that his left arm which was being used for transfusion was painful and there was some extravasation of blood. A hematoma was noted. It appeared that the needle had dislodged and blood was infiltrating into the surrounding tissues. The catheter was removed, pressure was applied and he went home. The mass in the arm slowly increased in size but neither thrill nor pulsation was noted. He gradually developed weakness in his hand, however, which progressed to a full-fledged median nerve entrapment syndrome. The patient was admitted to the hospital. When the surgical service was consulted, he had median nerve weakness in his right hand. The 10 x 10 cm mass was present at the right elbow which was pulsatile



**Figure 1**
**False aneurysm of brachial artery. Arrow points to fistual tract.**

and had an audible bruit. The arterial right arm venous fistula made it difficult to determine whether this was transmissed or primarily in the mass itself. The remainder of the patient's physical examination was unremarkable.

Appropriate angiographic studies were ordered.

**Dr. Harvey Neiman:** A selective injection into the brachial artery on the left side was performed in the first patient. There was good flow in both the ulna and the radial arteries. The fistula itself was seen with demonstration of a large vein draining from the fistula. A slightly later film from the same run showed satisfactory vascularization of the hand.

More proximally, however, there was a small accumulation of contrast material in the area of the brachial artery, which was clearly extravascular, sharply marginated, and somewhat less dense than the surrounding vascular structures. (Figure 1) A close-up view demonstrated that this sharply marginated extravascular structure was a pseudoaneurysm. (Figure 2) Thus, we have a nice arteriographic demonstration of pseudoaneurysm and AV fistula.

A selective injection into the brachial artery was also carried out in the second case. The salient feature was marked ventral displacement of the brachial artery. As the injection was made, a collection of contrast material was detected which became larger, much more dense and was clearly extravascular.



**Figure 2**
**Early filling of brachial vein (arrow) with aneurysm distorting vein lumen.**

A faint hypervascular rim in the area of the mass, indicated some organization of an inflammatory rind beginning around the accumulation of fluid in the antecubital fossa. (Figure 3) There was good vascularization distally. There was also a small accumulation of contrast material in a pseudoaneurysm which was from a previous AV fistula from the radial artery.

**Dr. Joseph Gavron:** From the angiographic evidence of the first patient, a diagnosis was made of traumatic arterio-venous fistula with pseudoaneurysm. The patient was prepared for operation. The patient's puncture site could still be seen in the antecubital fossa, as well as the mass which had gradually enlarged over the preceding several weeks. Thrill and bruit could be heard along the whole venous side of the fistula. The lesion was excised.

Approximately three months after his injury, the second patient had a useless hand on the right side. His arm was contracted and he had lost extension and flexion. At the time of operation, a pseudoaneurysm was found and excised.



**Figure 3**
**Large false aneurysm of brachia artery with extravasation of contrast into the aneurysm. Note zone of contrast outlining the wall of the aneurysm (arrows).**

## General Discussion

Iatrogenic vascular trauma and complications are more common than generally thought. Increasing urban violence, the recent conflict in Viet Nam and industrial accidents have contributed to large numbers of vascular injuries. Iatrogenic vascular trauma from both diagnostic and therapeutic procedures is less dramatic. The increasing use of angiography and other invasive techniques make early recognition necessary so that repair can be performed promptly to prevent permanent and disastrous consequences.

Most of the iatrogenic cases reported in the literature are associated with angiography, including cardiac catheterization procedures. Bilansky and Killan collected a series of 3,934 cases of angiography at their institution, where 33 patients required surgical intervention for correction of the vascular trauma, approximately 0.8%. Overall complications from angiographic procedures vary but are reported to be between one and three percent. The remaining ⅓ of injuries are due mainly to surgery and miscellaneous procedures. Dialysis injuries, such as the two reported today, have not been documented in the literature, but it is likely that there have been similar episodes elsewhere. Ligation of major vessels has occurred during both elective and emergency surgery. A femoral artery cannulization for cardiac bypass presents another hazard.

Several reports in the literature describe arterio-venous fistulas between the iliac artery and vein following lumbar disc surgery. In addition, there are reports describing iliac arterio-venous fistulus occurring after gynecological procedures.

The Fogarty catheter is an instrument commonly used in vascular surgery and there have been reports of complications from its use. Most have involved rupture of the artery by an over-inflated balloon. There have been perforations by the tips of the catheter. Intimal tears or disruption can occur from passage of the catheter. Embolization of ruptured balloon fragments has occurred.

## Treatment Considerations

Evaluation of vascular trauma, especially iatrogenic trauma, includes a careful physical examination. Peripheral pulses must be described carefully: Whether the pulses are present at all, and if absent, were they absent before the injury? Has there been a change in the pulse? If arteriovenous fistula or pseudoaneurysm is suspected, a thrill or bruit should be sought. Angiography is of great help in distinguishing the type of vascular abnormality. Doppler flow studies help determine whether there is some change from the preoperative or earlier state.

In general, management depends upon the type of injury or abnormality. Good long term results depend upon early recognition of the problem combined with expeditious surgical intervention.

**Dr. Julius Conn, Jr.:** These cases are presented to illustrate problems that can occur from arterial or venous cannulation. Blood gas determinations, for example, are a frequent laboratory test today and the arterial puncture is thought to be harmless. However, when we are called upon to construct an arterio-venous fistula for vascular access on patients who have had blood gasses drawn within the previous week, we often find that the distal radial artery has thrombosed. This is asymptomatic in the majority of the patients we see, but if such a patient has an occlusion of the ulnar artery or absence of the superficial Palmar arch, symptomatic ischemia may develop. About 20% of patients will have an absent superficial arch.

There are two groups of patients at increased risk from arterial cannulation. These are patients with systolic hypertension or a wide pulse pressure. I think these were etiologic factors in the two patients presented today. Both had distal arterio-venous fistulae. Because of the wide pulse pressure, they had developed dilated tortuous

vessels that were in close proximity. Whoever did the needle stick did not take into account that at the antecubital fossa, the median basilic vein immediately overlies the brachial artery. When they are tortuous and dilated, it is very easy to go through the wall of the vein and into the artery when placing a needle. That is what happened to the first patient. We found the hole in the back wall of the vein and the side of the artery. In the second patient, the venous puncture site healed and continued to bleed into the hematoma which was contained in a tight fascial compartment. This led to development of the false aneurysm. Again, he had a wide pulse pressure and an artery and vein immediately up against each other.

It is important to be aware of patients with arteriovenous fistulae because you are going to be seeing more and more of them coming into the emergency room or the hospital with problems other than renal failure. We are now beginning to put fistulae into patients who are on long standing chemotherapy, so that they will have access sites for the long term drug injection. Fistulae also may be used for patients on intermittent or home therapy with hyperalimentation. Therefore, if you are going to draw blood from these patients, you have to be aware of the proximity of arteriolized veins to major arteries.

Also, any patient who has an arterio-venous fistula or has had an arterial stick, who (a) reports sudden onset of local or distal pain, (b) develops any nerve deficit (whether motor or sensory), or (c) develops unexplained heart failure, must be evaluated very carefully for the presence of either a false aneurysm or false aneurysm with arterio-venous fistula. It is the nerve damage that often brings them to your attention, because as the hematoma expands, there is pressure on neighboring nerves. In the post-Viet Nam experience, one of the most common causes of delayed peripheral neuropathy in a patient who had had some type of arm or leg puncture wound was the development of arterio-venous fistula with pressure on adjacent nerves.

**Dr. John Beal:** Dr. Conn, I understand that the first patient had evidence of an AV fistula, and that one of the reasons it was noticed was her increased heart size. This would suggest that the patient had developed an increase in blood volume and cardiac output as a result of the AV fistula. Would you tell me why this occurred and why the patients don't have this as a complication of the usual AV fistula created for dialysis?

**Dr. Julius Conn, Jr.:** Generally, the fistulas we put in are low on the forearm or low on the leg so that there is a great deal of peripheral resistance in the extremity. If you have a proximal fistula which lowers peripheral resistance both blood flow and the right heart return increase, and there is less pressure on the aortic baroreceptors. As a result, the heart rate increases, blood volume increases, and ventricular hypertrophy and eventually heart failure ensue. When the fistula is distal (below the elbow or below the knee), heart failure and the other cardiodynamic changes are extremely rare. We have studied fistulas of this type for as long as two years and found no increase in heart work, stroke volume, or heart failure in patients on dialysis.

**Dr. John Beal:** In the second patient after you removed the aneurysm, did the patient's nerve function improve?

**Dr. Julius Conn, Jr.:** He is only a month postop and already has full extension of his elbow. He has been relieved of the more or less continuous pain in his hand, which is beginning to show improved motor function. The edema of his hand has markedly decreased. ◄


**COOK COUNTY**
**Graduate School of Medicine**

CONTINUING EDUCATION COURSES
STARTING DATES—1978

COMPREHENSIVE REVIEW PSYCHIATRY, 5 days, April 3
CLINICAL & LABORATORY DIAG. OF HEMORRHAGIC AND THROMBOTIC DISORDERS, 2 days, April 7
SPECIALTY REVIEW UROLOGY, 5 days, April 10
BASIC SEMINAR & WORKSHOP IN ECHOCARDIOGRAPHY, April 19
SPECIALTY REVIEW PULMONARY DISEASE, April 24
STATE & NAT'L. BD. REV. BASIC, April 30, CLINICAL, May 8
ESSENTIALS OF DERMATOLOGIC PROBLEMS, 5 days, May 1
ADVANCES IN SURGERY, 5 days, May 8
SPECIALTY REVIEW NEPHROLOGY, May 8
SPECIALTY REVIEW RHEUMATOLOGY, May 8
SPECIALTY REVIEW ANESTHESIOLOGY, 6 days, May 14
SPECIALTY REVIEW OBSTETRICS & GYNECOLOGY, May 15
ADVANCES IN FAMILY MEDICINE, 5 days, May 15
REFRESHER COURSE IN DIAG. RADIOLOGICAL PHYSICS, May 15
SPECIALTY REVIEW HEMATOLOGY, May 15
SPECIALTY REVIEW INFECTIOUS DISEASE, May 15

*Information concerning numerous other continuation courses available upon request.*

**Address:**
**REGISTRAR, 707 South Wood Street,**
**Chicago, Ill. 60612**

# *Emergency Medical Identification*

## A Critical Difference in Treating Acutely Ill Patients

By Robert E. Carlson, M.D. and Addy Weinstein, B.S./Chicago

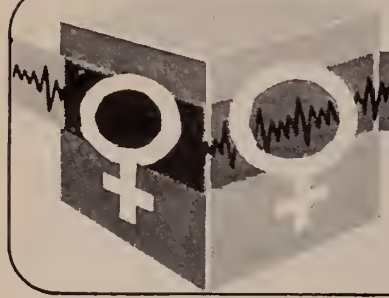
The increasingly mobile nature of American society requires that hospitals cope with unique problems in delivering emergency care to patients with whom they have had no previous contact. Patients often walk, drive or are flown in for medical treatment in states of consciousness that inhibit their communicative abilities. These patients may not be able to relate their hidden medical conditions. Emergency department nurses and physicians will attest to the fact that treatment can be expedited and hospital costs contained when the patient with a hidden medical problem wears an alerting device.

Consider the increasing number of patients with complicated medical problems who are alive today because of advances in surgical and pharmacological techniques. Many lives are maintained by multiple medications and prosthetic devices. Many complicated cases, now alive and well, could potentially come into the emergency room for their first consultation with a given physician.

If this patient wears a Medic Alert emblem, the physician can call a phone number engraved on it, give the indicated patient identification number, and obtain a list of current medications, name and telephone number of the private physician taking care of this patient and other vital information. There is sometimes no substitute for contacting the private physician for those minute details that cannot be gleaned from the short, written report that is kept on file in the central offices of the Medic Alert Foundation. The availability of this information is essential to continuity of medical care.

There are numerous emergency medical identification systems, each with its own features. The Medic Alert Foundation, a charitable, not-for-profit organization, is the only such organization endorsed by the American Hospital Association, most state and metropolitan hospital associations and many medical groups. Medic Alert is unique for its bracelet or necklace alerting device, its 24-hour emergency answering service that accepts collect calls from anywhere in the world, its annually issued wallet card and $10 lifetime membership. In addition, the system facilitates necessary changes in a members' medical record.

Professional education materials and application forms are offered at no cost. For further information, write the Medic Alert Foundation, 840 N. Lake Shore Drive, Chicago 60611 or its headquarters at P.O. Box 1009, Turlock, CA 95380.



# *pulse...* of the ISMS auxiliary

Mrs. Eugene Vickery, Editor



## *A Full Circle*

Mrs. Earl V. Klaren, President, ISMSA

Golden Anniversary Year and Annual Meeting have come to an end and auxiliary moves ahead with a new theme and a new slate of officers. Many service programs are planned to improve the quality of life in our communities and the image of medicine. Hopefully, the year will bring joy and friendship among auxilians throughout Illinois—joy in accomplishment and friendship in sharing common interests and concerns.

"Teach the Children" programs will continue in necessary areas, but the current theme is "Fifty One To Grow On." New board members and county people were given a real "spurt" for growth by an innovation at this year's convention called "Auxiliary Tomorrow." At this session, new board and committee members were introduced and asked to present tentative programs and goals. County representatives have taken these ideas home in plenty of time for next year's planning. In a true "workshop" atmosphere, materials were distributed that could be put to work immediately at the county level.

In addition to continuing with immunization and "CPR" Training, a special emphasis will be placed on Benevolence—reacquainting members with its purposes and needs and recommending ways to increase contributions. One vehicle is a packet of memorial cards that can be sold and kept handy for convenient and quick use. Inquire about these new packets and get them into doctors' and spouses' desks. It's a new way to grow.

A special committee has been set up this year to study the concerns of medical widows and divorcees. To further illustrate concern for our own, the Impaired Physician will be of prime interest to this year's president and board. Long Range Planning suffered a slow start as an infant last year, but an infusion of enthusiasm and interest will see it grow and contribute to auxiliary future.

This year's president is well experienced in auxiliary work, including AMAERF, Legislation, Membership and Programming. These committees will not lack for guidance and should flourish in this nurturing atmosphere. New officers were elected at the Annual Meeting to lead the Illinois State Medical Society Auxiliary in 1978-79:

| | |
|---|---|
| Mrs. Earl Klaren (Jane) | President |
| Mrs. R. Samuel Hoover (Shiela) | President-Elect |
| Mrs. Harlan Failor (Pat) | 1st Vice President |
| Mrs. Don Hinderliter (Diane) | 2nd Vice President |
| Mrs. Harold Keegan (Bonnie) | 3rd Vice President |
| Mrs. Julian Buser (Dorothy) | Recording Secretary |
| Mrs. Robert Webb (Sue) | Treasurer |
| Mrs. Edward Szewczyk (Betty) | Director |
| Mrs. William Hodges (Jean) | Director |
| Mrs. Jaime Gomez (Maria) | Director |

As the Illinois 50th Annual Convention takes its place in the annals of history, plans now turn to the American Medical Association Auxiliary annual meeting in St. Louis, Missouri, June 18-21. Delegates will be offered program orientation and scientific joint programming with the AMA Council on Continuing Education. Speakers include author and lecturer Bjorn Secher. Open forums, and the opportunity to experience a colorful national convention in an old and interesting city will provide further highlights. Social events will include a dinner cruise and a tour of Botanical Gardens. Attendance as a delegate or a guest at a national convention offers an opportunity for personal and auxiliary growth.

Participate and toast 'Fifty-one to Grown On."

*Guest Editor, Mrs. Edward Szewczyk*

## *WHOOPS*



(L-R) Margaret English, 1952-53 ISMSA president and former AMAA president, Mrs. G. Henry Mundt, the first ISMSA president (1928) and Mrs. Belle Chenault, former AMAA president from Alabama.

This photo was published in the March, 1978 quarter newsletter, "Pulse of the ISMS Auxiliary," as part of a photo-story about ISMSA past presidents.

Unfortunately, the photo was incorrectly cropped, and showed only Mrs. Mundt and Mrs. Chenault, who were identified in the caption as Mrs. English and Mrs. Mundt.

We're sorry.




GENERAL SURGEON

General Surgeon, Board Certified or eligible, preferrably with vascular experience for full time position in department of surgery open on or about July 1, 1978. Department has a primary affiliation with University Medical School in Chicago. Salary dependent on training and experience. Excellent fringe benefits.

Direct all inquiries with C.V. to:
E. G. EICHBAUM, M.D.
CHAIRMAN DEPT. OF SURGERY

OAK FOREST HOSPITAL
15900 S. CICERO AVE. OAK FOREST, ILLINOIS 60452

an Equal Opportunity Employer M/F

# Physician Recruitment Program

*In an effort to reduce the number of towns in Illinois needing physicians, the Physician Recruitment Program and the Doctor's Job Fair, are publishing synopses in the Journal.*

*Physicians who are seeking a place to practice or who know of any out-of-state physicians seeking an Illinois residence are asked to notify the Program.*

*Any areas wishing to be listed should contact: Mrs. E. Duffy, Physician Recruitment Program, ISMS, 55 E. Monroe, Suite 3510, Chicago, 60603.*

**BRAIDWOOD:** Physician for family practice, 20 miles south of Joliet—60 miles south of Chicago. No other doctor in town of 5,000. Next door to pharmacy. Clinic provided, substantial guaranteed income for 17 hours per week. One year contract. Contact: Ron Radley, Box 795, Braidwood 60408. (815) 458-2224 or (815) 634-4900. (6)

**CANTON:** Coleman Clinic, Ltd. Population 15,000; drawing area 60,000. Twelve physicians; multi-specialty clinic. Planning expansion program. Progressive city and clinic offering outstanding opportunity to primary care physician. Guaranteed salary and excellent benefits. Contact: H. E. Crouch, 175 S. Main St., Canton, 61520. (309) 647-0201. (6)

**CASEY:** Family physician. Practice quality rural medicine having advantage of group, but independence of solo practice. New complete facilities. Financial assistance available. This is the area to work, live, and enjoy families. Superb congenial doctors & colleagues to share your work. Before you decide, come see our operation. Contact: B. F. Vondracek, Casey Medical Center, Casey, 62420. (217) 932-4061. (6)

**CHADWICK:** Rural community in picturesque Northwestern Illinois, 125 miles west of Chicago. Need for a family physician in a solo practice or possible clinical association. Office space available. Contact: Harold Frank, 411 First St., Chadwick, 61014, (815) 684-5154 or 684-5147, Allen Smith, Rural Route, Chadwick, 61014, (815) 684-5200 or 684-5152. (6)

**CHICAGO:** Dr. Charles Chadbourn is looking for a doctor to take over practice immediately. Practice consists of obesity, industrial, some private and public aid patients. 7948 S. Western Ave. Call Marilyn at 436-2552 for appointment. (5)

**DeKALB:** Northern Illinois University. Physician for women's intercollegiate athletic teams and primary care practice in large university health service. Excellent facilities and working conditions, ideal community, good geographic location. Salary based on qualifications; Illinois license required. Start August 15 or earlier. Continuing 9 or 12 month contract. AA/EOE. L. W. Akers, M.D., Director, UHS, Northern Illinois University, DeKalb, Illinois 60115. (8)

**DOUGLAS COUNTY:** Population 20,000. Family practitioners needed in Villa Grove and Arcola. Twenty-five miles from Champaign and University of Illinois. 58 bed general acute hospital in Tuscola. Contact: J. Lindsey, Qualicare Inc., P.O. Box 24189, New Orleans, LA 70184, (504) 837-6456. (6)

**FAIRFIELD:** Population 6,000. Rural area with a service population of 25,000. Seventy miles from Evansville, Indiana. Opening in medical clinic for obstetrician-gynecologist, family practitioner, or internist interested in doing family practice. Financial assistance available. Contact: Dr. Arthur Marks or Dr. Sigmund Konarski, 101 E. Center Street, Fairfield, 62837. Telephone: (618) 842-2187. (6)

**FORT MADISON, IOWA:** Openings for 2-4 FP/GP, Ped., in growing industrial city of 16,000 serving 70,000 on Mississippi River. Solo, partnership, clinic available. Substantial salary, other incentive. U. of Ia. near, excellent living area, 125 bed accredited hospital. Contact Donald A. Buckert, Fort Madison Community Hospital, Fort Madison, Ia. 52627. (319) 372-6530. (7)

**FREEPORT:** Internist-general internist or internist with sub-specialty, board certified or eligible to join multi-specialty group in community of 35,000 in Northern Illinois. Excellent salary first year then partnership. Excellent retirement and fringe benefits. Send curriculum vita and references to K. H. Shons, Business Manager, Freeport Medical Clinic, Ltd., 3103 West Stephenson Road, Freeport, 61032. (815) 235-6131 (7)

**GALESBURG:** Excellent opportunities in ENT, Family Practice, Internal Medicine, Ob-Gyn. West-central Illinois community of 40,000, manufacturing & agricultural center. Home of Knox College. Outstanding educational, recreational, and cultural environment. Financial incentives and new medical office building available. Contact: Marshal G. Maggard, President, Galesburg Cottage Hospital, Galesburg, 61401. (309) 343-8131. (6)

**HERRIN:** Population 10,000. Trade area 40,000. Located in beautiful vacationland of Southern Illinois, near major university and medical school. Family Practice and OB-Gyn needed. Solo or clinic available. Excellent financial program provided. Modern well equipped hospital. Call collect or write, Larry Feil, Herrin Hospital, Herrin, 62948—Tel. (618) 942-4710. (7)

**ILLINOIS:** The Illinois Department of Mental Health and Developmental Disabilities has opportunities in all areas of the state for psychiatrists and primary care physicians. M.D.'s and D.O.'s with Illinois licenses will be considered. Competitive salaries commensurate with training and experience; attractive fringe benefits. Contact: John T. Nelson, M.D., Coordinator of Medical Affairs, 750 South State Street, Elgin, 60120. (312) 742-1040, x321. (6)

**JACKSONVILLE:** Opportunities for family practice, internal medicine, ENT, orthopedic surgery, emergency room. Progressive 250 bed hospital, 40 member medical staff. Prosperous community with service area of 60,000, two colleges, excellent schools, 30 miles from medical school. Financial assistance, office facilities available. Contact: Bernie Gregory, Passavant Hospital, Jacksonville 62650. (217) 245-9541. (6)

**LIBERTYVILLE:** Family practice physician, general practitioner, or internist to join outpatient clinic in rapidly growing area near lakes, shopping centers, recreation areas, and easy access to Chicago theaters, museums and cultural events. Clinic consists of full auxiliary facilities, special procedure rooms and future outpatient surgical center. For information contact: Family Medical Center, Rt. 1, Box 351, Libertyville 60048, (312) 362-9097. (6)

**MENDOTA:** General practice, second physician for Wholistic Health Center of Mendota, Illinois. Innovative program with additional staff for counseling and patient education. Excellent local hospital. Future openings available in five other Wholistic Health Centers in the planning stage. Call or write: Lucy Young, M.D., 607 Tenth Ave., Mendota, 61342. (815) 539-3888 (7)

**MUNSTER:** Industrial and Emergency Room physician needed for large midwest multispecialty clinic. Trauma oriented physician only need apply. Competitive first year salary with opportunity for early equal Partnership in 60 man group. All fringes clinic paid—most liberal vacation and PG allowance. No investment required. Send CV to: Thomas R. Hofferth, Hammond Clinic, 7905 Calumet Ave., Munster, IN 46321. (219) 836-5800 (5)

**PEORIA:** Emergency physician—Unique opportunity to start on the ground floor with fee-for-service group in 550-bed medical center seeing 27,000 ER visits. Need career-minded physician for three 16-hour shifts per week with four weeks paid vacation. Compensation 57K with excellent corporate benefits plus incentive compensation. Flexible scheduling to allow individual pursuits in university town of 250,000 in Central Illinois. Contact: Hospital Emergency Physicians S.C., 221 Northeast Glen Oak, Peoria, 61636; phone 309-672-4974. (8)

**PITTSFIELD:** Family practitioners and surgeons interested in locating in rural community area needed. Population 4100; area 18,000. Excellent opportunity for some one wanting to practice in a rural community. Located between Jacksonville, Illinois and Quincy, Illinois on Highways 54 and 36. Contact Mr. Gary Deer, 217-285-2113. (5)

**PRINCETON:** Family physician & internist—population 10,000, lovely community with excellent school and recreational facilities. Excellent hospital facility built in early 1970's. New office building attached to hospital will be completed in Spring of 1978. Specialties of internal medicine, OB, orthopedics, pediatrics, surgery, and urology available to complement the family physician. Contact: Harold L. Autrey, 530 Park Avenue East, Princeton 61356. (815) 875-2811. (6)

**SPRINGFIELD:** Family practitioners — Springfield Community Hospital is looking for you to begin private practice in our new multi-specialty Community Medical Plaza. We offer an attractive package to help you get started. If interested, contact: W. H. Fields, Springfield Community Hospital, 5230 S. 6th St., Springfield, 62703. (217) 529-7151. (6)

**UNION COUNTY:** Population 17,000. Clinic and office facilities available for family practitioner and physician of internal medicine. Special Care Unit under construction in County Hospital. Nearby cities of Carbondale and Cape Girardeau 25 miles away. Recreational facilities plentiful. Contact: E. A. Helfrich, 517 N. Main, Anna, 62906 AC 618-833-5155. (7)


# IMMEDIATE OCCUPANCY

# park west medical plaza

## An Original Concept

*A one story medical and dental building with private entrances for each suite and ample, adjacent parking. A landscaped environment emphasizing your identity and ease of access for patients.*

SUPERB LOCATION

- *Near downtown Highland Park.*
- *3 minutes from Highland Park Hospital.*
- *One block from Skokie Highway*

UNIQUE FEATURES

- *Individual thermostatic controls in all suites.*
- *Private Toilets*

OUTSTANDING ENVIRONMENT

- *A totally efficient and relaxed atmosphere.*
- *The outstanding medical building in the Chicago area.*

COMPLETE DESIGN FLEXIBILITY

- *Architect designed and built to suit you.*
- *Easy installation of any facilities within suites.*

For Leasing Information Contact:

Milico Development Co. 5500 W. Touhy Avenue Skokie, Illinois 60076 (312) 674-7033




# Who's Behind the CMA?

By Barbara McCray
Second Year Medical Assistant Student, Triton College

CMA—it's a statement in itself. The title Certified Medical Assistant is an assurance of quality, proficiency and professionalism. But who's behind that title? What type of person decides to become a CMA—or is there a "type"?

The CMA is a person who serves people, to comfort, support and attend to all needs, both medical and non-medical. This is a difficult task to undertake, but the CMA is qualified. The CMA is trained to view the individual as a whole: a necessary concept in successful and complete health care.

The patient has more roles in life than that of "patient." These may include worker, parent, student, brother, homemaker—the list is literally endless. The CMA is qualified because of her training, yes, but also because she shares a common bond with her patients. She also has many roles to play and maintain in her life.

Her professional roles may vary to include lab worker, bookkeeper, physiotherapy assistant, receptionist, examination room assistant and others too numerous to mention.

Personally the CMA also has widely diversified roles. She may be a student, mother, primary wage earner, wife, sister, amateur mechanic, artist or sports fan. She may have held previous jobs or be fresh out of a two-year M.A. program after high school. She may have earned a degree in an entirely different field before deciding to become an important member of the health care team.

Most of us are required to switch from one role to another or to juggle two at once with an ease that is deceptively simple. Personal knowledge of such a situation brings the ability to appreciate and empathize with every person who walks into the physician's office.

The title CMA denotes an individual who has a quality of proficiency and professionalism that has been tested and proven beyond question. With this assurance, look beyond the title and see this person as a whole—a person who has at least one thing in common with you: her humanity.

So, who's behind the CMA? Simple: people, one of whom could very well be you.

NONPARTISAN

# IMPAC

**ILLINOIS MEDICAL POLITICAL ACTION COMMITTEE**
55 East Monroe Street
Chicago, Illinois 60603
312/782-1963

This will be my last column as IMPAC Chairman, since my term expired with the 1978 IMPAC annual meeting. I want to share some thoughts with you on the last two years and their significance for IMPAC, for physician political involvement, and for organized medicine in general.

For the first time in IMPAC's history membership is better than 50% of the total ISMS membership. We take personal pride in that statistic since it was one of the goals which we set for my term as your Chairman. We thank those of you who took it upon yourselves to help me in spreading IMPAC's message and in increasing IMPAC's membership. Without your assistance we could not have reached this goal. However, our membership is still only a little more than that 50% figure. That means that there are nearly as many of you who are not members of IMPAC as there are IMPAC members. Somehow we must redouble our efforts to seek out those non-members and convince them to join our cause.

Each year, the number of candidates who file for the legislature becomes greater. In addition, downstate candidates are beginning to come from a wider variety of cities. This means that we must rely more and more heavily on input from you if we are to accurately assess each candidate's views on health care issues. WE WANT TO HEAR FROM YOU -- if you have a good candidate of if you know of a bad one. IMPAC, if it is to do the kind of job it was intended, must have grassroots input. I cannot stress enough that we want your opinion on candidates from your home area.

The past two years have seen one tradition after another fall. Unfortunately, this trend seems to be beginning to affect medicine as well. The number of bills affecting your ability to practice medicine which have been introduced in the legislature has increased at an astounding rate. What is particularly frightening about this is that many of them would seek to restrict your medical judgment while expanding the powers of others over medicine -- people such as government bureaucrats, allied professionals, etc. IMPAC has been successful in fighting this onslaught largely because of your local involvement and good rapport with your legislators. I cannot stress strongly enough that that rapport must continue if we are to be as successful in the future as we have been in the past.

I wish the picture I am painting could be brighter. Unfortunately, I do not think it can be. But there is some degree of hope for medicine -- if physicians and their spouses do not lose sight of one important fact. Medicine will survive the next few years if physicians support it -- if physicians do not become so involved in their day-to-day practice that they forget about their patients' long-term well-being. I challenge each of you to remember that the only way the profession can survive is if we as members work to strengthen it.

Thank you for allowing me to serve in this position.

Pam Taylor
Chairman

Contributions are not limited to the suggested amount. Neither the Illinois State Medical Society nor the AMA will favor or disadvantage anyone based upon the amounts of or failure to make pac contributions. Copies of IMPAC & AMPAC reports are filed with the Federal Election Commission, Washington, D.C. Contributions are subject to the limitations of FEC regulations, Sections 110.1, 110.2 & 110.5. (Federal regulations require this notice.) IMPAC reports are also filed with the State Board of Elections, and are or will be available for purchase from the State Board of Elections, 1020 S. Spring St., Springfield, Illinois, 62704

# ISMS Guide to Continuing Medical Education

Compiled for Illinois physicians by the
ILLINOIS COUNCIL ON CONTINUING MEDICAL EDUCATION
55 E. Monroe St., Suite 3510 • Chicago, IL 60603 • (312) 236-6110

*Items for this Calendar must be received 90 days prior to the event. Those received earlier may appear in up to three monthly issues.*

*WARNING! Items for this Calendar come from many sources, often far in advance of the publication date. Sometimes, cancellations or changes in date, place or time occur too late to be corrected before publication. You are urged to contact the sponsoring organization to confirm information given below.*

## MAY

### *Anesthesia*

**SPECIALTY REVIEW IN ANESTHESIOLOGY**
**For:** Anesthesiologists. Lecture, May 14, 1978, Cook County Graduate School of Medicine. **Speaker:** Alon P. Winnie, M.D. **Hrs. of Instr.:** 45. **CME Credit:** AMA Category 1. **Fee:** $250.00. **Reg. Limit:** 300. **Sponsor:** Cook County Graduate School of Medicine, 707 South Wood Street, Chicago, IL. **Contact:** Robert J. Baker, M.D., Dean. **Telephone:** (312) 733-2800.

### *Cardiology*

**AUSCULTATION**
**For:** FP's IM's and Thoracic. Lecture, May 17, 1978; 2:30 PM, Central DuPage Hospital, Winfield Road, Winfield, IL. **Speaker:** Robert J. Adolph, M.D., Director, Cardiac Research Laboratory, U. of Cincinnati. **Hrs. of Inst.:** 3. **CME Credit:** AMA Category 1 and AAFP Elective. **Fee:** None. **Reg. Deadline:** May 8, 1978. **Sponsor:** DuPage County Medical Society, 26 West St. Charles Road, Lombard, IL. **Contact:** Lillian S. Widmer, Executive Secretary. **Telephone:** (312) 495-4050.

### *Cardiology*

**ILLINOIS HEART ASSOCIATION SCIENTIFIC SESSION**
**For:** General Practitioners, Family Practitioners, Internists, Pediatricians, Pediatric Cardiologists, Ob Gyn. 1½ day symposium/lecture/workshops. May 25, 9:00 a.m.-5:00 p.m. and May 26, 8:30 a.m.-1:30 p.m. Champaign, Illinois. **Reg. deadline:** May 18. **Fee:** $45.00. **Reg. limit:** 300. **CME credit:** 13 hours, AMA category 1; AAFP Elective, 13 hours. **Sponsor:** Illinois Heart Association. **Co-Sponsor:** American Heart Association's Council on Clinical Cardiology. **Contact:** A. Paul Naney, M.D., Chairman, Professional Education & Scientific Session Task Force. **Telephone:** 217-525-1350.

### *Chest Diseases*

**CORONARY HEART DISEASE—UPDATE AND CONTROVERSIES**
**For:** Physicians, Nurses, Therapists. Two-day postgraduate course, May 11-12, 9:00 a.m.-4:00 p.m. Hyatt Regency, Chicago, Illinois. **CME credit:** 11 hours, AMA category 1. **Speaker:** Leon Resnekov, M.D. **Tuition:** ACCP members: $150, Nonmember physicians: $175, Residents, nurses, therapists: $100. **Sponsor:** American College of Chest Physicians, 911 Busse Highway, Park Ridge, Illinois 60068. **Contact:** Dale E. Braddy, Director of Education. **Telephone:** 312-698-2200.

### *Contemporary Medical And Surgical Management*

**PARATHYROID DISORDERS**
**For:** Physicians, Residents and Fellows. 2½-day Symposium, May 12, 13, 1978, Saint Joseph Hospital, 2900 North Lake Shore Drive, Chicago, IL. **Speaker:** Franklin D. Schwartz, M.D. and Louis T. Tenta, M.D. **Hrs. of Instr.:** 18. **CME Credit:** AMA Category 1. **Reg. Deadline:** April 14, 1978. **Reg. Limit:** 250. **Fee:** $50.00-$250.00. **Sponsor:** Medical Education Saint Joseph Hospital, 2900 North Lake Shore Drive, Chicago, IL. **Contact:** Sharon Afable, Admin. Asst., Medical Education. **Telephone:** (312) 975-3454.

### *Continuing Medical Education*

**1978 ANNUAL CONGRESS ON CME**
**For:** All MD's, DME's, Program Chairmen. May 5-6, 1978; Oak Brook Hyatt House, Oak Brook, IL. **Hrs. of Inst.:** 9. **CME Credit:** AMA Category 2. **Fee:** $50.00. **Reg. Limit:** 100. **Reg. Deadline:** April 21, 1978. **Sponsor:** Illinois Council on Continuing Medical Education, 55 East Monroe, Suite 3510, Chicago, IL. **Contact:** Mrs. Joan Kipnis. **Telephone:** (312) 236-6110.

### *Dermatology*

**PRIMARY CARE DERMATOLOGY**
**For:** All physicians. Conference, May 19-21, 1978, Chicago, IL. **Hrs. of Instr.:** 17. **CME Credit:** AMA Category 1. **Reg. Limit:** 250. **Fee:** $150.00. **Sponsor:** Northwestern University Medical School, Center for Continuing Education, 301 East Chicago Ave., Chicago, IL. **Contact:** James E. Dyson, Ph.D., Director of Continuing Education. **Telephone:** (312) 649-8533.

### *Family Medicine*

**20th ANNUAL POSTGRADUATE SEMINAR**
**For:** Family Physicians. Lecture and Seminars, May 6-8, 1978, Hyatt Regency Chicago, Chicago, IL. **Hrs. of Instr.:** 16-22. **CME Credit:** AMA Category 1 and AAFP Prescribed. **Fee:** $20.00. **Sponsor:** Illinois Academy of Family Physicians, 1200 Harger Road, Suite 405; Oak Brook, IL. **Contact:** H. Marchmont-Robinson, M.D., Executive Director. **Telephone:** (312) 325-8502.

### *Family Therapy*

**A DAY WITH VIRGINIA SATIR**
**For:** Mental Health Practitioners and Physicians. One-day workshop, May 20, 1978; 9:30 AM-4:30 PM. Regency Hyatt Hotel, 150 East Wacker Drive, Chicago, IL. **Speaker:** Virginia Satir, Palo Alto, California. **Hrs. of Inst.:** 6. **CME Credit:** AMA Category 1. **Fee:** $70.00. **Sponsor:** Center for Family Studies/The Family Institute of Chicago, 10 E. Huron, Chicago, IL. **Co-Sponsor:** Institute of Psychiatry, Northwestern Memorial Hospital and Northwestern University Medical School. **Contact:** Belinda M. Stone, Secretary for Workshops/Conferences. **Telephone:** (312) 440-1414.

### *Family Therapy*

**A RATIONAL APPROACH TO PAIN**
**For:** Physicians. Lecture, May 9, 1978, Sherman Hospital, Elgin, IL. **Speaker:** Alon P. Winnie, M.D., Head, Dept. of Anesthesiology, University of Illinois. **Hrs. of Inst.:** 2. **CME Category** 1. **Fee:** None. **Sponsor:** CME Committee, Sherman Hospital, 934 Center Street, Elgin, Illinois 60120. **Contact:** Mary Anne Stiegemeier, Secretary. **Telephone:** (312) 742-9800, Ext. 649.

### *Internal Medicine*

**MIDWESTERN STUDY CONFERENCE**
**For:** Internists and General Practitioners. Lecture, May 11-13, 1978, Chicago, IL. **Speaker:** Ward E. Perrin, D.O. **Hrs. of Instr.:** 18. **CME Credit:** AOA (pending). **Fee:** $125.00. **Sponsor:** Chicago College of Osteopathic Medicine, 5206 South University, Chicago, IL. **Co-Sponsor:** American College of Osteopathic Internists. **Contact:** Marie E. Kowalsky, Director of Special Events. **Telephone:** (312) 947-4606.

### *Internal Medicine*

**SPECIALTY REVIEW COURSE IN INFECTIOUS DISEASE**
**For:** Infectious Disease Specialists. Lecture, May 15, 1978, Cook County Graduate School of Medicine, 707 South Wood Street, Chicago, IL. **Speaker:** Stuart Levin, M.D. **Hrs. of Instr.:** 40. **CME Credit:** AMA Category 1. **Reg. Limit:** 150. **Fee:** $200.00. **Sponsor:** Cook County Graduate School of Medicine. **Contact:** Robert J. Baker, M.D., Dean. **Telephone:** (312) 733-2800.

### *Internal Medicine*

**SPECIALTY REVIEW COURSE IN NEPHROLOGY**
**For:** Nephrologists. Lecture, May 8, 1978, Cook County Graduate School of Medicine, 707 South Wood Street, Chicago, IL. **Speaker:** Norman Simon, M.D. **Hrs. of Instr.:** 40. **CME Credit:** AMA Category 1. **Reg. Limit:** 150. **Fee:** $200.00. **Sponsor:** Cook County Graduate School of Medicine. **Contact:** Robert J. Baker, M.D., Dean. **Telephone:** (312) 733-2800.

### *Internal Medicine*

**SPECIALTY REVIEW COURSE IN RHEUMATOLOGY**
**For:** Rheumatologists. Lecture, May 8, 1978, Cook County Graduate School of Medicine, 707 South Wood Street, Chicago, IL. **Speaker:** Herbert M. Rubinstein, M.D. **Hrs. of Instr.:** 40. **CME Credit:** AMA Category 1. **Reg. Limit:** 150. **Fee:** $200.00. **Sponsor:** Cook County Graduate School of Medicine. **Contact:** Robert J. Baker, M.D., Dean. **Telephone:** (312) 733-2800.

### *Internal Pulmonary Medicine*

**SPECIALTY REVIEW COURSE IN PULMONARY DISEASE**
**For:** Pulmonary Specialists. Lecture, May 1, 1978, Cook County Graduate School of Medicine, 707 South Wood Street, Chicago, IL. **Speaker:** John T. Sharp, M.D. **Hrs. of Instr:** 40. **CME Credit:** AMA Category 1. **Reg. Limit:** 150. **Fee:** $200.00. **Sponsor:** Cook County Graduate School of Medicine. **Contact:** Robert J. Baker, M.D., Dean. **Telephone:** (312) 733-2800.

### *Medicine*

**STATE AND NATIONAL BOARD REVIEW, CLINICAL**
**For:** Internists and Family Practitioners. Lecture, May 8, 1978, Cook County Graduate School of Medicine, 707 South Wood Street, Chicago, IL. **Speaker:** Sheldon S. Waldstein, M.D. **Hrs. of Instr.:** 53. **CME Credit:** AMA Category 1. **Reg. Limit:** 150. **Fee:** $250.00. **Sponsor:** Cook County Graduate School of Medicine. **Contact:** Robert J. Baker, M.D., Dean. **Telephone:** (312) 733-2800.

### *Medicine*

**IMMUNOLOGY IN HEMATOLOGY AND ONCOLOGY**
**For:** Practicing Physicians. Lecture, May 24, 1978; 8:00 AM. Chicago, IL. **Speaker:** John Robinson, M.D. **Hrs. of Inst.:** 2. **CME Credit:** AMA Category 1. **Fee:** None. **Sponsor:** Medical Staff of Louis A. Weiss Memorial Hospital (Levinson CME Fund), 4646 North Marine Drive, Chicago, IL 60640. **Contact:** Barry J. Millman, Associate Director. **Telephone:** (312) 878-8700, Ext. 304.

### *Medicine*

**CLINICAL CONSIDERATIONS IN HEMOLYTIC ANEMIAS**
**For:** Practicing Physicians. Lecture, May 10, 1978; 8:00 AM. **Speaker:** Walter Fried, M.D. **Hrs. of Inst.:** 2. **CME Credit:** AMA Category 1. **Fee:** None. **Sponsor:** Medical Staff of Louis A. Weiss Memorial Hospital (Levinson CME Fund), 4646 North Marine Drive, Chicago, IL. **Contact:** Barry J. Millman, Associate Director. **Telephone:** (312) 878-8700, Ext. 304.

*Medicine*

**ILY PRACTICE REVIEW**
Family Practitioners. Lecture, May 15, 1978. ker H. Marchmont-Robinson, M.D. **Hrs. of** .: 45. **CME Credit:** AMA Category 1. **Reg. Limit:** Fee: $200.00. **Sponsor:** Cook County Graduate ol of Medicine. **Contact:** Robert J. Baker, M.D., . **Telephone:** (312) 733-2800.

*Musculo-Skeletal Trauma*

**ICAL HOSPITAL PROGRAM ON CULO-SKELETAL TRAUMA**
All Physicians. Lecture, May 11, 1978, 8:00-0 PM, John B. Murphy Auditorium, 50 East Street, Chicago, IL. **Hrs. of Instr.:** 2. **CME** it: AAFP Elective and AMA Category 1. **Fee:** . **Sponsor:** Chicago Committee on Trauma of the rican College of Surgeons, 11255 West 74th et, LaGrange, IL. **Co-Sponsor:** University of Chi- Hospital & Clinics. **Contact:** Mrs. Lillian Husa, utive Secretary. **Telephone:** (312) 482-8686.

*Obstetrics/Gynecology*

**CIALTY REVIEW IN OBSTETRICS AND ECOLOGY**
Gynecologists and Obstetricians. Lecture, May 15, 3, 8:00 AM, Cook County Graduate School of icine, Chicago, IL. **Speaker:** John G. Masterson, **Hrs. of Instr.:** 83. **CME Credit:** AMA Category 1. Limit: 125. **Fee:** $400.00. **Sponsor:** Cook Coun- raduate School of Medicine, 707 South Wood et, Chicago, IL. **Contact:** Robert J. Baker, M.D., . **Telephone:** (312) 733-2800.

*Radiology*

**RESHER COURSE IN DIAGNOSTIC IOLOGICAL PHYSICS**
Radiologists. Lecture, May 15, 1978, 8:00 AM, County Graduate School of Medicine. **Speaker:** dore Fields, M.S. **Hrs. of Instr.:** 44. **CME** it: AMA Category 1. **Reg. Limit:** 75. **Fee:** .00. **Sponsor:** Cook County Graduate School of icine, 707 South Wood Street, Chicago, IL. act: Robert J. Baker, M.D., Dean. **Telephone:** ) 733-2800.

*Surgery*

**ANCES IN SURGERY**
Surgeons. Lecture, May 8, 1978, 8:00 AM, Cook ty Graduate of Medicine, Chicago, IL. **Speaker:** rt J. Baker, M.D. **Hrs. of** fnstr.: 40. **CME** it: AMA Category 1. **Reg. Limit:** 100. **Fee:** .00. **Sponsor:** Cook County Graduate School of icine, 707 South Wood Street, Chicago, IL. **Con-** Robert J. Baker, M.D., Dean. **Telephone:** (312) 2800.

***RECENT CME ACCREDITATIONS***

**The ISMS Committee on CME Accreditation has recently approved the CME Programs of these institutions:**

**Alfred Adler Institute of Chicago**
**Chicago Neurological Society Chicago**
**Chicago Surgical Society Chicago**
**Louise Burg Hospital Chicago**
**Lutheran General Hospital Park Ridge**
**Martha Washington Hospital Chicago**
**Norwegian-American Hospital Chicago**
**Silver Cross Hospital Joliet**
**Skokie Valley Community Hospital Skokie**
**Tinley Park Mental Health Center Tinley Park**

*Trauma*

**22nd ANNUAL POSTGRADUATE COURSE ON FRACTURES AND OTHER TRAUMA**
**For:** Orthopaedic surgeons, general surgeons, general physicians, surgeons. 3½ day annual event, May 10-13, Sheraton-Chicago Hotel, Chicago, Illinois. **Speaker:** Marcus J. Stewart, M.D. **CME credit:** AAFP elective, 28 hours; AMA category 1, 28 hours. **Fee:** $175.00. **Sponsor:** Chicago Committee on Trauma of the American College of Surgeons. **Contact:** Ralph T. Lidge, M.D., American College of Surgeons, 55 East Erie Street, Chicago, Illinois 60611. **Telephone:** 312-392-4320.

*Urology*

**CLINICAL PROBLEMS IN UROLOGY**
**For:** Physicians. Lecture, May 10, 1978, 2:00-5:00 PM, 950 East 59th Street, Chicago, IL: **Hrs. of Instr.:** 3. **CME Credit:** AAFP Elective and AMA Category 1. **Fee:** $20.00. **Sponsor:** The University of Chicago, Frontiers of Medicine, 950 East 59th Street, Chicago, IL. **Contact** Elaine Ehrman, Secretary. **Telephone:** (312) 947-5777.

# *JUNE*

*Cardiology*

**ANNUAL REVIEW OF CARDIOLOGY FOR THE INTERNIST**
**For:** Cardiologists. Two-day lecture, June 8-9, 9:00 a.m., Chicago, Illinois. **Speaker:** Kenneth Rosen, M.D. **CME credit:** 30 hours, AMA category 1. **Fee:** $225. **Sponsor:** Cook County Graduate School of Medicine, 707 South Wood Street, Chicago, Illinois 60612. **Contact:** Robert J. Baker, M.D., Dean. **Telephone:** 312-733-2800.

*Chest Diseases*

**HYPERSENSITIVITY LUNG DISEASE**
**For:** Physicians, nurses, therapists. Three-day postgraduate course, June 21-23, The Playboy Resort, Lake Geneva, Wisconsin. **CME credit:** 17 hours, AMA category 1. **Fee:** ACCP members, $160; Nonmembers, $185; Residents, nurses, therapists, $125. **Sponsor:** The American College of Chest Physicians, 911 Busse Highway, Park Ridge, Illinois 60068. **Co-sponsor:** Medical College of Wisconsin. **Contact:** Dale E. Braddy, Director of Education. **Telephone:** 312-698-2200.

*Family Medicine*

**CEREBRAL VASCULAR INSUFFICIENCY**
**For:** Physicians. Lecture, June 20, 1978; 7:30 PM. Assembly Hall, Sherman Hospital, 934 Center Street, Elgin, Illinois. **Speaker:** Hushang Javid, M.D., Professor of Surgery, Rush Medical College. **Hrs. of Inst.:** 2. **CME Credit:** AMA Category 1. **Fee:** None. **Sponsor:** CME Committee, Sherman Hospital, 934 Center St., Elgin, IL. **Contact:** Mary Anne Stiegemeier, Secretary, CME Committee. **Telephone:** (312) 742-9800.

*Internal Medicine & Surgery*

**FLUIDS & ELECTROLYTES**
**For:** Internists and Surgeons. Three-day lecture, June 15-17, 9:00 a.m., Chicago, Illinois. **Speaker:** Robert J. Baker, M.D. **CME credit:** 24 hours, AMA category 1. **Fee:** $175. **Sponsor:** Cook County Graduate School of Medicine, 707 South Wood Street, Chicago, Illinois 60612. **Contact:** Robert J. Baker, M.D., Dean. **Telephone:** 312-733-2800.

*Medicine*

**RECENT ADVANCES IN INFECTIOUS DISEASES**
**For:** Physicians. Lecture, June 14, 1978. 950 East 59th St., Chicago, IL. **Hrs. of Inst.:** 6. **CME Credit:** AAFP Elective and AMA Category 1. **Fee:** $30.00. **Sponsor:** The University of Chicago, Frontiers of Medicine, 950 East 59th St., Chicago, IL. **Contact:** Elaine Ehrman, Secretary. **Telephone:** (312) 947-5777.

*Medicine/Surgery*

**TWENTIETH MEDICAL SURGICAL SEMINAR FOR LAKE COUNTY**
**For:** Physicians, et al. Seminar, June 21, 1978. Mother Leonarda Hall, St. Therese Hospital, Waukegan, IL. **Hrs. of Inst.:** 5. **CME Credit:** AAFP Elective, AMA Category 1 and AOA. **Fee:** None. **Reg. Deadline:** June 20, 1978. **Sponsor:** St. Therese Hospital, 2615 Washington, Waukegan, IL. **Contact:** R. M. Adelman, D.D.S., M.D., Vice President—Medical Affairs. **Telephone:** (312) 688-5800.

*Pediatric Neurosurgery*

**SECOND ANNUAL POST-GRADUATE COURSE IN PEDIATRIC NEUROSURGERY**
**For:** Pediatric Neurosurgeons. 5-day conference, June 27-July 1, 1978. Alumni Center for Continuing Education, 301 East Chicago Ave., Chicago, IL **Hrs. of Inst.:** 35. **CME Credit:** AMA Category 1. **Fee:** $315.00. **Sponsor:** Northwestern University Medical School, Alumni Center for Continuing Education. **Contact:** James E. Dyson, Ph.D., Director, Continuing Education. **Telephone:** (312) 649-8533.

*Surgery*

**MANAGEMENT OF COMMON SURGICAL PROBLEMS**
**For:** Surgeons. Conference, June 15-16, 1978. Chicago, IL. **Hrs. of Inst.:** 12. **CME Credit:** AMA Category 1. **Fee:** $125.00. **Reg. Limit:** 250. **Sponsor:** Northwestern University Medical School, Center for Continuing Education, 301 East Chicago Ave., Chicago, IL. **Contact:** James E. Dyson, Ph.D., Director of Continuing Education. **Telephone:** (312) 649-8533.

*Surgery & Oncology*

**CURRENT CONCEPTS IN MANAGEMENT OF COMMON NEOPLASMS**
**For:** Surgeons and Oncologists. Three-day lecture, June 12-14, 8:00 a.m., Chicago, Illinois. **Speaker:** Tapas K. Das Gupta, M.D. **CME credit:** 24 hours, AMA category 1. **Fee:** $175. **Sponsor:** Cook County Graduate School of Medicine, 707 South Wood Street, Chicago, Illinois 60612. **Contact:** Robert J. Baker, M.D., Dean. **Telephone:** 312-733-2800.

# *JULY*

*Family Medicine*

**SPECIALTY REVIEW FOR FAMILY PRACTICE**
**For:** Family Practitioners. 11-day lecture, beginning July 17, 8:30 a.m., Chicago, Illinois. **Speaker:** Harry Marchmont Robinson, M.D. **CME credit:** AAFP Elective, 98 hours; AMA category 1, 98 hours. **Fee:** $400. **Reg. limit:** 200. **Sponsor:** Cook County School of Medicine, 707 South Wood Street, Chicago, Illinois 60612. **Contact:** Robert J. Baker, M.D., Dean. **Telephone:** 312-733-2800.

*Medicine*

**SPECIALTY REVIEW COURSE IN INTERNAL MEDICINE/CERTIFYING (PREP. FOR BOARD)**
**For:** Internists. 6½ day lecture, beginning July 30 & August 6, 1:00 p.m., Chicago, Illinois. **Speaker:** Sheldon S. Waldstein, M.D. **CME credit:** AMA Category 1, 64 hours. **Fee:** $275. **Reg. limit:** 600. **Sponsor:** Cook County Graduate School of Medicine, 707 South Wood Street, Chicago, Illinois 60612. **Contact:** Robert J. Baker, M.D., Dean. **Telephone:** 312-733-2800.

*Pediatrics*

**SPECIALTY REVIEW IN PEDIATRICS**
**For:** Pediatricians. 5½ day lecture, July 10-15, 8:30 a.m., Chicago, Illinois. **Speaker:** Ira DuBrow, M.D. **CME credit:** 44 hours, AMA catgeory 1. **Fee:** $250. **Reg. limit:** 200. **Sponsor:** Cook County Graduate School of Medicine, 707 South Wood Street, Chicago, Illinois 60612. **Contact:** Robert J. Baker, M.D., Dean **Telephone:** 312-733-2800.

*Radiology*

**RADIATION SAFETY & DIAGNOSTIC RADIOLOGY**
**For:** Radiologists. 3-day lecture, July 24-26, 8:00 a.m., Chicago, Illinois. **Speaker:** Theodore Fields, M.S. **CME credit:** 24 hours, AMA category 1. **Fee:** $175. **Reg. limit:** 75. **Sponsor:** Cook County Graduate School of Medicine, 707 South Wood Street, Chicago, Illinois 60612. **Contact:** Robert J. Baker, M.D., Dean. **Telephone:** 312-733-2800.

*Surgery*

**ADVANCED PERIPHERAL VASCULAR SURGERY**
**For:** Peripheral Vascular Surgeons 5-day lecture, July 17-21, 9:00 a.m., Chicago, Illinois. **Speaker:** Robert J. Baker, M.D. **CME credit:** AAFP elective, 40 hours; AMA category 1, 40 hours. **Fee:** $225. **Reg. limit:** 60. **Sponsor:** Cook County Graduate School of Medicine, 707 South Wood Street, Chicago, Illinois 60612. **Contact:** Robert J. Baker, M.D., Dean. **Telephone:** 312-733-2800.

*Surgery*

**FIBEROPTIC COLONOSCOPY**
**For:** Surgeons, Internists & Family Practitioners. 3-day lecture, July 12-14, 9:00 a.m., Chicago, Illinois. **Speaker:** Herand Abcarian, M.D. **CME credit:** AAFP elective, 19 hours; AMA category 1, 19 hours. **Fee:** $300. **Reg. limit:** 15, **Sponsor:** Cook County Graduate School of Medicine, 707 South Wood Street, Chicago, Illinois 60612. **Contact:** Robert J. Baker, M.D., Dean. **Telephone:** 312-733-2800.

*Surgery*

**FIBEROPTIC ESOPHAGOGASTRIC ENDOSCOPY**
**For:** Surgeons & Internists. 3-day lecture, July 12-14, 9:00 a.m., Chicago, Illinois. **Speaker:** C. Thomas Bombeck, M.D. **CME credit:** AAFP elective, 19½ hours; AMA category 1, 19½ hours. **Fee:** $300. **Reg. limit:** 15. **Sponsor:** Cook County Graduate School of Medicine, 707 South Wood Street, Chicago, Illinois 60612. **Contact:** Robert J. Baker, M.D., Dean. **Telephone:** 312-733-2800.

## *Rheumatology Rounds*

L. F. Layfer, M.D., and J. V. Jones, M.D., Contributing Co-Editors

# Extensor Tendon Rupture In A Rheumatoid Hand

A 58-year-old white female was seen for inability to extend the fingers of her left hand. Onset of seropositive rheumatoid arthritis had begun two years earlier, when she noticed "puffiness" about the ulnar styloid after playing golf. The swelling would increase in size and become painful after strenuous use of her wrists and would improve with rest. Over the next three months the disease spread to both knees and shoulder and to multiple interphalangeal joints of hands and feet. Nodules over her elbows were noted. The swellings on the dorsum of her wrists became chronic and thickened. She was placed on aspirin, gold, and physical therapy, and subsequently on chloroquine and imuran without substantial response.

Two months prior, the patient had noticed that the fourth and fifth digits of her left hand were "dangling" and that she was unable to extend them. Neither pain nor numbness were associated. The patient could not remember exactly when it began, but remembered normal function in the recent past.

On examination, the patient demonstrated destructive changes of chronic rheumatoid arthritis in multiple joints. Thickened synovium was palpable over the dorsum of both wrists and especially prominent near the ulnar styloids, which were subluxed upwards. The wrists were tender, with flexion and extension limited and supination virtually impossible. The hands revealed enlarged interphalangeal joints with ulnar deviation and several swan-neck deformities. Flexion of the digits was possible but grip was poor. Extension of the fourth and fifth digits on the left was impossible. Sensory examination of the hands was normal and tinels sign was negative. Thumb motion was normal in all directions.



**Figure 1A**




**Figure 1B**

**X-rays in another patient illustrate similar changes. The AP view (A) reveals soft tissue swelling near the ulna which is sharpened at its tip. The oblique view (B) shows the loss of extensor function in the fourth and fifth digits.**

## Laboratory Findings

Complete blood count, SMA 18, EKG, urinalysis and coagulation studies were normal. Sedimentation rate was 106 mm/hr. Rheumatoid factor was 1:1280 latex; 1:640 sheep cell. Antinuclear antibody was speckled at 1:20; anti-DNA and anti-ENA titers were negative. Complement component levels were normal. X-rays showed changes of chronic rheumatoid disease (see Figure 1).

## Comment

One of the most common clinical manifestations of rheumatoid arthritis is swelling of the dorsal and extensor tendon sheaths about the wrist (see Figure 2). The tendons near the wrist are encased in sheaths lined with synovium, which became distended with fluid early in the illness. They later become thick and filled with hypertrophied synovium pathologically similar to the pannus seen in chronic rheumatoid joints. Rupture may occur, most probably from variable combinations of mechanical and inflammatory erosions.[1] Mechanical erosions appear about the roughened edge of the ulnar styloid, which is frequently subluxed dorsally into the tendons. Subluxation also occurs over listers tubercle near the thumb. Inflammatory erosion involves the invasion of pannus through the tendons much as it invades cartilage and bone in joints.

The most common ruptured tendon is the extensor digiti minimi. This causes loss of fifth finger extension.[2] It is generally followed in weeks to months by rupture of the fourth, third and second tendons, usually in sequence. Multiple simultaneous ruptures may occur. Another commonly ruptured tendon is the extensor pollicis longus, leading to inability to extend the thumb.[3] No pain is felt with rupture. Some patients notice the loss of function immediately, but others may attribute it to the joint disease itself and thus do not report it to the physician.[4]

Tendon rupture is treated surgically.[1] The procedure can involve transfer of the distal part of the ruptured tendon to an adjacent intact tendon; multiple tendon transfers; or tendon grafts using the palmaris longus tendon. End to end repairs are not feasible due to the distance between healthy portions of the ruptured ends. Resection of the ulnar styloid and synovectomy of tendon sheaths is generally done in an attempt to prevent further rupture.

Prophylactic synovectomy[5] and ulnar styloid resection can be utilized in an attempt to prevent tendon rupture. Ulnar styloid resection also aids in restoring supination to the wrist.[6] It is useful to be aware of disease near the wrist and to consider prophylactic surgery in some cases. These include those where (1) one tendon is already ruptured; (2) a dorsally subluxed ulna is present; (3) thickened synovium is present at the wrist; or (4) swelling persists dorsally despite systemic treatment of rheumatoid arthritis.



**Figure 2**
**Swelling of tendon sheaths over the dorsum of the right wrist is illustrated.**

## Conclusion

The progressive synovial thickening and ulnar subluxation were thought to have lead to rupture of the extensor tendons in the present case. The patient was referred to a hand surgeon for repair. At operation, the distal end of the ruptured fifth tendon was sewn to the distal end of the ruptured fourth, which was in turn anastomosed to the adjacent intact third extensor tendon. A synovectomy of the other extensor tendons, including the extensor pollicis longus, was done,

as well as a synovectomy of the wrist itself and resection of the ulnar styloid. Thick pannus was noted in all tendon sheaths. Post-operatively the patient responded well, with return of extensor function and improved supination. Prophylactic synovectomy and ulna resection are planned for the other wrist in the near future. The patient was begun on penicillamine in an effort to control her progressive rheumatoid disease. ◄

### References


1. Nalebuff, E. A.: "Surgical Treatment of Tendon Rupture in the Rheumatoid Hand," *Surgical Clinics of North America,* 49:811-822, 1969.
2. Nalebuff, E. A. and Potter, T. A.: "Rheumatoid Involvement of Tendon and Tendon Sheaths in the Hand," *Clin. Orthop.,* 59:147-159, 1968.
3. Harrison, S., Swannell, A. J., Ansell, B. M.: "Repair of Extensor Pollicis Longus using Extensor Pollicis Brevis in Rheumatoid Arthritis," *Ann. Rheum. Dis.,* 31:490-492, 1972.
4. Ehrlich, G. E., Peterson, L. T., Sokoloff, L., Bunim, J. J.: "Pathogenesis of Rupture of Extensor Tendons at the Wrist in Rheumatoid Arthritis," *Arth. and Rheum.,* 2:332-346, 1959.
5. Clayton, M. L.: "Surgical Treatment at the Wrist in Rheumatoid Arthritis," *J. Bone Joint Surg.,* 47-A:741-750, 1965.
6. Rana, N. A. and Taylor, A. R.: "Excision of the Distal End of the Ulna in Rheumatoid Arthritis," *J. Bone Joint. Surg.,* 55-B:96-104, 1973.


# *EKG*

*(Continued from page 258)*

**Answers: 1. E. 2. D.**

The ECG shows sinus rhythm at a rate of 96 beats per minute. There are large Q waves in leads $V_1$ to $V_4$ with ST segment elevation compatible with an extensive acute anteroseptal myocardial infarction. The QRS duration is prolonged to 0.14 seconds with an R wave in lead $V_1$, complete right bundle branch block. Left axis deviation is present since this ECG pattern occurred acutely and was associated with serum enzymes compatible with an acute myocardial infarction. This suggests that the left anterior descending coronary artery was occluded. This is a critical artery for the left ventricle since it supplies the ventricular free wall, apex and interventricular system. This is a serious infarction accompanied by congestive heart failure and suggests a large area of necrosis of the myocardium. The ECG in this case confirms the extent of the damage. For further reading on this subject, see Dr. Dean Mason: "Congestive Heart Failure," Yorke Medical Books, 1976.


**LOW-COST GROUP INSURANCE ANOTHER ISMS MEMBERSHIP PRIVILEGE**

**THE GROUP DISABILITY PLAN** ● Provides up to $1,732.00 monthly in the event of disability caused by Accident or Sickness. ● Special Guaranteed renewal feature. ● Protect your income and security.

**BUSINESS OVERHEAD EXPENSE PLAN** ● Pays your office overhead expense when disability strikes. ● Premiums are Tax Deductible. ● Pays in Addition to the Disability Plan Benefits.

**THE BASIC MAJOR MEDICAL EXPENSE PLAN** ● In or out of Hospital Benefits up to $25,000.00 per Disability. ● Up to $100.00 Daily Hospital Room and Board maximum. ● Subject to choice of deductible and 80% coinsurance.

**EXCESS MAJOR MEDICAL PLAN** ● Provides up to $250,000 for Medical Expenses. ● Supplements **any** Basic Major Medical Plan and has a $25,000 deductible. ● Low group rates. ● Truly **catastrophic coverage.**

FOR INFORMATION, ASSISTANCE & DETAILS CONTACT:

Administrators:
PARKER, ALESHIRE & COMPANY
ESTABLISHED 1901
Insurance

9933 N. Lawler Avenue
Skokie, Illinois 60076
Phone: 312-679-1000

# Lift the Quality of Medicine You Practice to A New High!



**American Medical Association/127th Annual Convention**
**June 17-21, 1978/St. Louis**

**Continuing Medical Education Highlights!**

The whole purpose of the AMA's CME program is to help you do what attracted you to medicine in the first place: provide the high quality care your patients need.

The scientific program is geared to help you do exactly that. Emphasis is on the *practical* aspects of new developments—clinical information of immediate use in your practice. Whether you're in primary care or a specialty, the large selection of courses allows you to focus on those areas in which you want to update your knowledge. The program features:

- 55 Category 1 Postgraduate Courses
- 30 Sessions, 20 Telecourses, 13 Clinical Dialogues, 3 Motion Picture Seminars — all Category 1 and FREE OF CHARGE
- 100 Scientific and 125 Industrial Exhibits
- 3 AMA Auxiliary Sessions (no credit)

**The New Spirit of St. Louis!**

New convention center. New hotels. New attractions. There's a whole new look and spirit in St. Louis today. With lots of things to do and see. Soar to the top of the nation's tallest monument, the Gateway Arch. . .beat your feet to rollicking ragtimers aboard a showboat. . .dine on gourmet French cuisine whose recipes came up the river from New Orleans. . .visit the hospitality room of the world's largest brewer. The new Spirit of St. Louis is yours to enjoy at the 127th AMA Annual Convention.

**PLAN NOW TO ATTEND**

**For complete information, return this coupon today.**

Dept. of Meeting Services
American Medical Association
535 N. Dearborn/Chicago, IL 60610

Please send me complete information on the 127th AMA Annual Convention in St. Louis as soon as it becomes available.

Name_____

Address_____

City/State/Zip _____

# CLASSIFIED ADVERTISING

## POSITIONS & PRACTICE OPPORTUNITIES

**OB-GYN, ENT, PEDIATRICS, SPECIALISTS** needed by 16-man multi-specialty clinic in university community of 50,000 in western Wisconsin; excellent retirement and fringe benefits; fine recreational opportunities; salary negotiable. Send curriculum vitae and references to: John R. Ujda, M.D., La Crosse Clinic, 212 South 11th Street, La Crosse, Wisconsin 54601.

**FULL TIME PHYSICIAN** for Industrial Clinic in Skokie. Surgical experience needed. Salary negotiable. Must have Illinois license. Call (312) 674-4800, Mrs. McCubbin.

**OPPORTUNITIES FOR PHYSICIANS IN INDIANA**—There are several excellent openings among the Indiana State Hospitals at various locations throughout the state for psychiatrists and physicians of other specialties, at most experience levels. A newly-revised salary schedule offers a very competitive income plus a generous package of fringe benefits. An adjunct practice is possible beyond the regular working hours and on-call responsibilities. Please reply with a copy of the c.v. to: Farabee & Associates, Inc., P.O. Box 472, Murray, KY 42071 or call (collect) (502) 753-9772. Farabee is retained by the Indiana Department of Mental Health.

**EMERGENCY PHYSICIAN, McHENRY:** Full-time career-oriented emergency physician to begin July 1 in 17,000 visit/year emergency department of 140-bed mobile-intensive-care resource hospital and trauma center 50 miles northwest of Chicago. Small town (pop. 8,000). Ski and water sports area. Good back-up from 20-man multi-specialty clinic in adjacent building and from independent specialists in community. Salary and fringes competitive with Chicago area. Send curriculum vitae to: John L. Bowman, M.D., Director, Emergency Services, McHenry Hospital, 3516 W. Waukegan Road, McHenry, IL 60050.

**PSYCHIATRIST:** Board eligible or board certified with license to practice in Illinois or ability to obtain same. Full time position with well established community mental health center located in a very attractive area of northwestern Illinois ninety minutes from metropolitan Chicago. Income and fringe benefit package highly competitive and negotiable. Excellent opportunity for the right person who is committed to inter-disciplinary team approach, community mental health models of intervention, and a lifestyle that combines the best of rural living with access to urban stimulation. Psychiatric services would include both outpatient and inpatient components. For additional information, contact Albert E. Graff, Executive Director, Sinnissippi Mental Health Center, Dixon-Sterling Freeway, Dixon, Illinois 61021. Phone collect (815) 284-6611.

**MEDICAL DIRECTOR:** Excellent opportunity for administratively oriented physician. Work in program design at the central office and practice at the new diagnostic and evaluation center. Supervise approximately 50 health care personnel. Excellent state benefits, salary to start in the mid 40's. Send resume to: Dept. of Correctional Services, P.O. Box 94661, Lincoln, Nebraska 68509.
An Equal Opportunity Employer

**EMERGENCY PHYSICIANS—FULL OR PART TIME:** needed for Danville, Peoria, Streator, Princeton, Monmouth, and Moline, Illinois; compensation to $75,000. Prefer physicians with prior E.R. experience. CPR training is required. Call 800-356-9034 or send C.V. to Central States Emergency Physicians, P.O. Box 659, Moline, Illinois, 61265.

**SOUTHERN MEDICAL CENTER** will be seeking a Family Practice physician and a General Internal Medicine physician with Illinois licenses or reciprocity status. The private practice is in a newly remodeled building for physicians and allied health services. Excellent salary guarantee with participation in excess, fringe benefits. Office expenses and malpractice paid. Hospital will pay recruiting expenses for physician and family. Call 618/734-2400 or write Harvey H. Pettry, Administrator, Southern Medical Center, 2020 Cedar Street, Cairo, IL 62914.

**ACADEMIC DIRECTOR, INTERNAL MEDICINE:** University of Illinois affiliated community hospital seeks individual to be responsible for undergraduate, graduate and continuing medical education, and administration of residency and outpatient center. Physician we seek must be American Board of Internal Medicine certified. In return we offer a challenging and rewarding experience plus a competitive salary and benefit program. Send resume in complete confidence to: Box 917, c/o IMJ, 55 E. Monroe, Suite 3510, Chicago 60603.

**GENERAL PRACTITIONER** for office-based practice with multi-specialty group in western suburbs of Chicago. Attractive minimum guarantee salary plus incentive. Complete fringe benefit package. Write for details: Dave S. Bauer III, Administrator, Glen Ellyn Clinic, S.C., 454 Pennsylvania Ave., Glen Ellyn, IL 60137.

**OTOLARYNGOLOGIST** to join large multi-specialty group as second ENT doctor in western suburbs of Chicago. Very busy practice. Guaranteed base salary plus incentive; Early partnership. Complete fringe benefit package. Box 918, c/o IMJ, 55 E. Monroe, Suite 3510, Chicago, 60603.

**EMERGENCY PHYSICIAN:** Off-duty 3 weeks out of 5 weeks. Corporate group of 6, non-hospital employees, double physician coverage during peak loads, 40,000 visits yearly in autonomous emergency department. Salary $60,000, bonus, plus $31,500 in untaxed fringe benefits, including premiums for malpractice, disability family health & accident, $1,000,000 major medical, fringe benefit reimbursement, $50,000 life insurance policies, professional society dues, profit sharing & pension plan funds. Central Illinois college town, 100,000 population. Primarily interested in U.S. trained, emergency medicine career physician. Apply by submitting curriculum vita to: Box No. 919, c/o IMJ, 55 E. Monroe, Suite 3510, Chicago, 60603.

**INTERNIST AND FAMILY PHYSICIAN:** Established need for both an internist and family physician to join seven man group in beautiful Northwest Iowa. New clinic building of 10,000 sq. ft. is located next door to 88-bed county hospital. Unusually progressive community of 10,000 offers 3,000 acre lake, 85+ acres of parks and recreation, local liberal arts college, and many family interest features. Generous salary with incentive, malpractice insurance, liberal vacation and seminar time, partnership in one year. Contact D. A. Pritchard, Administrator, Buena Vista Clinic, 620 Northwestern Drive, Storm Lake, Iowa 50588.

**WANTED: INDUSTRIAL PHYSICIAN:** Unusual opportunity for Illinois licensed physician. Full time industrial work with minor traumatic surgery and physical examinations. Regular hours. Advancement for right person. Starting salary negotiable. Write to Box 920, c/o IMJ, 55 E. Monroe, Suite 3510, Chicago, 60603.

## FOR SALE, LEASE OR RENT

**MEDICAL OFFICE** for rent, Moline, Illinois, downtown location. Present occupant retiring OB-GYN. 725 feet, reception room, business area, private office, three examining rooms, laboratory, storage and rest room. Basement 375 feet. Rest room, laboratory and drug room. Contact Warren R. Streed, D.D.S., 719 16th Street, Moline, Ill. 61265.

**MEDICAL CLINIC**—For rent, lease, or sale. Immediately available, retiring, take over practice, fully equipped modern brick building; well over $100,000 gross; 5 hospitals in area; full community cooperation; suitable for two; 25 miles south of State Capitol. For further information, contact Ted Lay Agency, Box 34, Girard, Illinois 62640. (217) 627-2515 or 627-2835.

**MODERN MEDICAL SUITE,** Homewood area: 800 sq. ft. available immediately. Reception plus 3 to 4 rooms, private bath. Panelled, carpet, air condition, all utilities paid and off-street parking. Convenient to all transportation and south suburban hospitals. Phone Mr. Olsen weekdays: 565-0025; Evenings: 798-8234.

**OFFICE TO SUBLET PART TIME:** professional building. Common waiting room with receptionist suitable for internist, psychiatrist, surgeon. To arrange days and hours call Monday, Tuesday, Thursday: 2-5. (312) 262-0399.

**SUBLEASE:** Part time-ophthalmologist's office. Completely furnished and equipped. (Garland Bldg.) Phone (312) 236-6368.

**MEDICAL OFFICE SUITE FOR RENT,** Lincoln-Belmont Bldg. 715 square feet, available July 1, 1978 in full service, elevator, active professional building. Call Gary Solomon, (312) 334-5400.

**FOUR ROOM MODERN SUITE** and waiting room. Medical Center, 10444 South Kedzie Avenue, Chicago, Ill. 60655, (312) 239-3000.

**MEDICAL CENTER FOR RENT.** Complete and ready to open. 4300 sq. ft. at 2301 E. 95th Street, Chicago. Large waiting rm., 18 exam rms., x-ray rm., central a/c & heat. Call Gary Solomon, (312) 334-5400.

**SUITE TO LEASE** for Internist, Pediatrician, Psychologist, Psychiatrist or other medical practice. Suite is located in a high quality building with a growing medical community situated across from a major hospital. The complex already includes an outstanding lab, X-ray facility, pharmacy and 16 professionals. Arrangement provides flexibility for the new tenant to share a suite with an existing practice, to have office built in newly created bare space and to participate in the ownership and direction of the complex. STRONG Property Managers, Ltd. Agents, 201 W. Springfield, Champaign, IL 61820. (217) 356-2617.

**FOR SALE:** Complete Office Physical Therapy Equipment. Includes Whirlpool and chair, Ultrasound and electrical stimulator, Shortwave diathermy, Paraffin Bath, 4 pack Hot Pack machine, 2 wooden tables for treatment, one high and one low. All new in 1975. Phone—618-532-4462.

**ESTABLISHED OBSTETRICIAN AND GYNECOLOGIST** moving to California. Fully equipped North Michigan Avenue office and equipment for sale in Chicago. Should be prepared to service current patients. Contact Box 921, IMJ, 55 E. Monroe, Suite 3510, Chicago, 60603.

## SITUATIONS WANTED

**CONSIDERING STAFF ADDITIONS?** Medical Assistants available throughout the state. Robert Morris College has a Medical Assisting Program accredited by the Council on Medical Education of the American Medical Association in collaboration with the American Association of Medical Assistants. Our Medical Assistants are proficient in administrative, clinical, and laboratory areas. Graduates are prescreened prior to application. No fee charged to Employer or Applicant. Call: Toll Free 800-252-9151 or (217) 357-2121; Robert Morris College Placement Center, College Avenue, Carthage, IL 62321.

**PHYSICIAN'S ASSISTANT,** BA, MA, 31, graduate of accredited program, Board eligible, work experience in group practice in major medical center. Relocating. Desires position in Chicago or Northern Illinois. Contact M. J. Van Hook, 1925 Keeney Street, Evanston, Illinois 60202.

**EXPERIENCED ER PHYSICIAN** wants to join emergency room hospital group in permanent ER position. Please write Box 910, c/o IMJ, 55 E. Monroe, Suite 3510, Chicago, 60603.

**RADIOLOGIST** seeks permanent part-time position, 4 hrs/day, fluroscopy and/or film reading. Chicago metropolitan area. Please write Box 911, c/o IMJ, 55 E. Monroe, Suite 3510, Chicago, IL 60603.

**UNIVERSITY TRAINED, LICENSED,** board eligible pediatrician seeks opportunities in DuPage, Will or Kane County in the West Suburban Chicago area. Has worked in general hospital and children's hospital pediatrics, Emergency Room experienced. Available July, 1978. Reply to IMJ, Box 914 c/o IMJ, 55 E. Monroe, Suite 3510, Chicago, 60603.

**FAMILY PHYSICIAN,** board eligible, seeks to purchase a practice or associate with another family physician or group practice in Chicago or nearby suburb. Reply Box 915, c/o IMJ, 55 E. Monroe, Suite 3510, Chicago, 60603.

**SITUATION WANTED:** Illinois licensed physician's assistant seeks position with M.D., medical group or clinic. Good references. Salary negotiable. Will consider re-locating. Call 815-744-3650 (Joliet).

**UROLOGIST,** FMG, board certified university trained, FLEX, seeks solo or group practice, available July, 1978. Contact: P. Satpathy, M.D., 6517 Landover Road, #102, Cheverly MD. 20785. (202) 745-1315, (301) 773-0380.

## MISCELLANEOUS

**WANTED TO PURCHASE:** Old EKG machine, workable, inexpensive. Phone (312) 332-4424.

## GUARANTY FUND CERTIFICATE

**GUARANTY FUND CERTIFICATE.** ISMIE Exchange #7761. Orig. cost $960.00, Class II 100-300,000 for sale. Please call: (312) 654-8447.

**FOR SALE:** Leaving Illinois for practice elsewhere. Will sell ISMIE Professional Ins. Guaranty Fund Certificate for $5500, a savings of $500.00 Please reply to Box 913, c/o IMJ, 55 E. Monroe, Suite 3510, Chicago, 60603.

**GUARANTY FUND CERTIFICATE** for sale: Class 5, Territory 11 for $1,000,000/1,000,000 coverage, purchase price $6024. For information, call Mr. Murr (815) 963-9674 or send inquiries to Box 916, c/o IMJ, 55 E. Monroe, Suite 3510, Chicago, 60603.

**GUARANTY FUND CERTIFICATE,** Number 1901, Illinois State Medical Inter-Insurance Exchange for sale. Territory 1 Class 1, Purchase Price $772. Best offer, contact Donald Gordon, M.D., Lutheran General Hospital, 1775 Dempster Ave., Park Ridge, IL 60068; Tel. (312) 696-2210.

**GUARANTY FUND CERTIFICATE** No. 1828, ISMIE, original cost $876.00. Coverage for Internal Medicine, Gastroenterology, contact: Zayd Kaylani, M.D., 1740 West 27th, Suite 303, Houston, TX 77008.

**FOR SALE:** Guaranty Fund Certificate—Class IV. Face Value $3420.00, good discount. Call (312) 852-6552.

**GUARANTY FUND CERTIFICATE** issued by the Illinois State Medical Inter-Insurance Exchange for sale. Coverage $100,000/$300,000. Class 5, Specialty: Otorhinolaryngology. Original purchase price $6,840.00. Interested: Contact Olawale O. Idewu, M.D. 9204 South Commercial Avenue, Chicago, Illinois 60617; Tel. (312) 735-8033 or 734-4243.

*IMJ and ISMS are not acting as brokers or agents; this is provided as a membership service.*


# Professionals are talking about . . .




# CLOVER LEAF TOWERS OFFICE PLAZA

**Ideally located & suited for professionals.**

10 MINUTES TO I-90 • 30 MINUTES TO CHICAGO

**NEW 3 STORY • ALL ELECTRIC • WITH ELEVATOR**

- Heating & Air-Conditioning Included
- Carpeting — Your Color Choice
- More Than Ample Parking
- Fine Restaurant Located in Building
- Ideal For Medical, Dental Offices
- Entire Floor 10,000 Sq. Ft. — Will Divide
- Tinted Glass — FM Music
- Public & Private Restrooms
- 2 Year Lease — No Increase
- Solid Oak Doors — Vinyl Base
- Individually Controlled Thermostat
- Immediate Occupancy — Brokers Invited

## CLOVER-LEAF REALTY

**201 E. Army Trail (1½ Miles West of Rte. 53)**
**Bloomingdale, Ill.**
**PHONE 893-1000**

# COLBY PROCLAIMS WOMAN SUFFRAGE

Signs Certificate of Ratification at His Home Without Women Witnesses.

MILITANTS VEXED AT PRIVACY.

Wanted Movies of Ceremony, But Both Factions Are

WASHINGTON, Aug. 26, 1920—




# Social Security Bill Is Signed Gives Pensions to Aged, Jo

*Roosevelt Approves Message Intended to Benefit 30, Persons When States Adopt Cooperating Laws-H the Measure 'Cornerstone' of His Economic Prog*

# SENATE APPROVES 18-YEAR OLD VOTE IN ALL ELECTIONS

Amendment to Constitution is Sent to House, Where Passage is Expected

WASHINGTON, March 10, 1971—The Senate approved today, 94 to 0, and sen

WASHINGTON, Aug. The Social Security Bill, a broad program of unei insurance and old age and counted upon to be 20,000,000 persons, beca day when it was signed dent Roosevelt in the p those chiefly responsibl ting it through Congr

Mr. Roosevelt call "the cornerstone i which is bein m

# TRUMAN CLOSES TED NATIONS CONFEREN ITH PLEA TO TRANSLATE CHARTER INTO DEEDS

# NEW WORLD HOPE

President Hails 'Great Instrument of Peace,' Insists It Be Used

HISTORIC LANDMARK

Meeting Gives Standing Ovation as Executive Pictures Peace Gain

"If we fail to use it," he declared to the solemn final meeting of the delegates, 'we shall betray all of those who have died in order that we might meet here in freedom and safety to create it.'

"If we seek to use it selfishly—for the advantage of any one nation or any small group of nations—we shall be equally guilty of that betrayal."

Fervent Interpolation

The President, speaking in the auditorium of the War Memorial Opera House, built in memory of sons of the Golden Gate city who gave their lives in the first World War, in which he himself served, seemed to give unconscious expression to the solemn feeling of the occasion when, at the outset of his speech, he interpolated the words, half a hope, half a prayer:

"Oh, what a great day this can be in history!"

Just before the plenary session

# IGN the Dra Ends N

WASHINGTON, Jan. 27, 1973—"With the signing of the peace agreement in Paris today, and after receiving a report from the Secretary of the Army that



# PATIENT PACKAGE INSERTS: A CONCEPT WHOSE TIME HAS COME?

*The consumer's right to know is an irreversible and desirable trend of the Seventies. It extends, and properly, to a patient's right to know more about his or her prescription medications. One way, gaining favor, is through patient package inserts. Wisely-prepared and properly distributed when medically indicated, they could markedly improve patient knowledge and drug therapy—laudable goals by anyone's standards.*

*The PMA endorses these goals and will work with government, the health professions and consumers to achieve them.*

## The Advantages

The concept holds promise of benefits: better patient understanding of the product prescribed, better adherence to the treatment plan, and more awareness of possible side reactions.

Every doctor has had patients who fail to finish antibiotic regimens because they feel better. Some patients assume that if one tranquilizer or analgesic is good, two may be twice as good. Still others fail to report dizziness while on antihypertensive therapy —and so on.

Problems like these might arise less often if the patient received written information in addition to verbal instructions. Some studies suggest that patients are more receptive to such materials, and they more often understand the verbal instructions and follow them, when inserts are used.

## The Disadvantages

There are also some potential problems. Obviously, the inserts must be clearly phrased, without extraneous or complex detail. How much information is enough? How can it be kept current? Should all patients receive the same information? Should inserts be included with all drugs? Should only potential problems be listed or are patients better off with a "fair balance" presentation that describes usefulness as well as drawbacks?

These and similar questions require answers, since model inserts have yet to be properly developed and tested. Despite the need for these studies, the FDA is proceeding prematurely with inserts on selected products. We think the Congress is the only place where the matter can be given the proper legal status and direction, particularly since it represents a conceptual change in the legal, medical and social framework of the nation's prescription drug information system.

## The Solution

The PMA believes that carefully-devised pilot studies of various kinds of inserts are needed. They should be developed and implemented with full participation by doctors, pharmacists, consumers, communications experts and the drug industry. Such studies will provide reliable pathways to follow, so that inserts will be useful aids to medical practice.

And particularly we think that you should be closely involved in this debate and in these studies and decisions. Otherwise, people with less experience and qualifications may control the purposes, content and use of a tool with considerable promise for improved patient care. It could make a difference in your practice tomorrow, and more importantly, in the health of your patients.

PMA
THE PHARMACEUTICAL MANUFACTURERS ASSOCIATION
1155 FIFTEENTH ST. N. W. WASHINGTON, D. C. 20005

# *Pediatric Perplexities*

## Ruth Andrea Seeler, M.D., Editor

*The Pediatric Perplexities series analyzes slightly uncommon pediatric disorders which require prompt diagnosis and specific management modalities. The editor welcomes suggested topics and questions from interested readers.*

# Mucocutaneous Lymph Node Syndrome

By Adisesha B. Reddy, M.D./Chicago

*This paper reports on a disease first discovered in Japan in 1967. Case report and discussion consider etiology and diagnosis. In the time lapse since this article was written, the author has treated two additional cases, and commented that the disease is perhaps more common than had been thought.*

The mucocutaneous lymph node syndrome (Kawasaki Disease), a febrile exanthematous disease, was originally recognized in Japan in 1967.[1] Additional cases have been reported from Hawaii and most recently by .physicians within the continental United States.[2-11] The disease is limited neither to Japan nor to people of oriental descent; it has been diagnosed in all races. Once the entity was described as a disease or syndrome, additional cases were quickly recognized worldwide. This paper reports a child with mucocutaneous lymph node syndrome recently seen at the Cook County Hospital.

### Case Report

A two-year-old black male was admitted in May, 1977, with a high fever of one week's duration which had not responded to antipyretics. Joint pains, particularly in the knees and wrists, had begun five days prior to admission and a diffuse rash four days prior to admission. The rash began on the face and spread to the chest and then to the extremities. Prior to this, the child had been in excellent health and had not travelled outside of the United States. He was "allergic" to penicillin, but the allergic manifestations were not stated. Family history revealed that a maternal aunt had systemic lupus erythematosis and a step sister had rheumatic fever.

Physical examination revealed temperature of 102.6°F., with a normal pulse, blood pressure, and respiratory rate. The nose was stuffy and throat mildly congested without any exudate. The lips were dry and indurated. The tongue was red and the papillae were hypertrophied, giving a so called "strawberry tongue" appearance. There was erythematous rash distributed extensively over the trunk and the extremities. There was objective swelling of both ankle joints with limitation of motion, tenderness and warmth. The child refused to walk. The fingers of both hands were fusiform in shape and tender. There was no hepatosplenomegaly or lymphadenopathy on the initial examination.

He was started on acetylsalicylic acid 100 mg/kg/day, but remained intermittently febrile, ranging from 100-104.5°F. during the eight day

ADISESHA B. REDDY, M.D., is a resident in the department of pediatrics of the Cook County Hospital and the Hektoen Institute for Medical Research.

hospitalization. Joint swellings gradually regressed and he began to walk on the third hospital day. On the fourth hospital day, desquamation began on the extremities and extended all the way under the fingernails. By the next day, patient had developed enlargement of one submandibular lymph node, which was nontender and measured 2x2 cm. Other than this one large node, there was no adenopathy. He was discharged and followed in the out-patient clinic. Fever and joint swellings completely subsided 3-4 days following discharge. The lymph node became non-palpable within the next week.

Extensive workup revealed normal chest and joint X-rays. The CBC showed a white blood count ranging from 18,500/$m^3$ to 21,000/$m^3$ with a predominance of polymorphonuclear leukocytes and juvenile forms. A representative CBC showed a white blood count of 21,000/$m^3$ with 58 polys, 23 bands, 13 lymphs, and 6 monos. The erythrocyte sedimation rate ranged from 55 to 60 mm/hour. Electrocardiogram, urinalysis, serum amylase were normal. The antinuclear antibody rheumatoid factor, blood cultures, febrile agglutinins, $B_1C$ complement and IgG, IgA, IgM immunoglobulin levels were all normal. ASO and anti DNASE titers were nondiagnostic. Viral titers for rubella, caxsackie showed no change at four week intervals.

On followup in the clinic the child has remained well within sequela.

**Discussion**

The patient is a rather classic example of the mucocutaneous lymph node syndrome which is characterized by fever, erythema of the lips and oral pharynx, including a "strawberry tongue," indurated edema of the hands and feet, arthralgia or arthritis, erythematous rash, desquamation of the skin to the fingertips, cervical lymphadenopathy, conjunctivitis, and in some cases, myocarditis.[3,4] In these patients the differential diagnosis includes juvenile rheumatoid arthritis, post streptococcal acute rheumatic fever, Stevens-Johnson syndrome and a variety of other non-specific viral exanthema. The major problem with this disorder is that no specific laboratory test makes the diagnosis. Recognition of the constellation of signs and symptoms is diagnostically crucial. Failure to recognize this can lead to an extraordinary amount of time and money on wasted laboratory tests, all of which are nondiagnostic.[10] Fever in the mucocutaneous lymph node syndrome has been a characteristically hectic spiking pattern, lasting from 7 days to 3 weeks, with a mean of approximately 10 days.[6] Antibiotics are without effect, and as our patient demonstrated, antipyretics are not very effective in reducing the fever.

In the continental United States, it would appear that this is a disease of young children in the age range of 3 months to 12 years. The peak in top age groups arrives at approximately 3 years. In constrast, the experience in Japan is around 18 months of age with a steady decline up to age 10 years.[10]

Indurated edema and erythema usually begin a few days following the onset of fever. It is frequently followed by the onset of a discreet macularpapular rash over the extremities which becomes generalized in a few days. In addition, arthritis and arthralgia may affect the hands and the feet as the most prominent facet of the symptom complex. Children are frequently unwilling to stand and walk and may have limited use of their hands during this stage of the disease. These symptoms last from 5-15 days and then gradually subside. Desquamation is quite characteristic in that it goes right up the tip of the fingers and just under the nail.[1] We noted this in our patient during convalescence.

The cervical lymphadenopathy usually begins as a single lymph node and is usually non-tender. The nodes are firm and non erythematous and may be unilateral or bilateral.

Our patient was also typical in that the oral pharynx was erythematous and slightly injected. The tongue papilla were characteristic of the "strawberry tongue" in streptococcal pharyngitis. This is an early sign of the disease and fades fairly quickly.

The mucocutaneous lymph node syndrome is somewhat unique in that it was first recognized in 1967 and subsequently reported from the rest of the world. It has recently been thought to be the more benign generalized form of infantile polyarteritis nodosa. The histology has been identical in fatal cases.[9] Fatal infantile polyarteritis nodosa has been known for a long time and only recently has the mucocutaneous lymph node syndrome been recognized and thought to be the mild end of the spectrum.

Infantile polyarteritis nodosa has a very high mortality rate. Death is due to the coronary artery involvement. The death rate in the mucocutaneous lymph node syndrome in Japan is approximately 2% and shows the same pathology, namely coronary artery involvement.[1] At the

moment, although they cannot be lumped as a single entity, there is good reason to consider mucocutaneous lymph node syndrome as the basic underlying problem and the fatal form carrying the title of infantile polyarteritis nodosa.

Nevertheless, that does not help establish the etiology of the mucocutaneous lymph node syndrome. Many features of this disease suggests an infectious etiology, but no specific organisms have been isolated and no serological evidence has been found to any of the recognized pathogens. Equally possible is an immunologic disorder. The recent finding of elevated IgE levels in some of the recent cases lends support to this theory.[9]

The mucocutaneous lymph node syndrome has protean symptoms and should be included in the differential diagnosis of febrile children with rashes. If the signs and symptoms are compatible and recognized, a long and involved hospitalization and workup can be avoided. ◄


### Acknowledgment

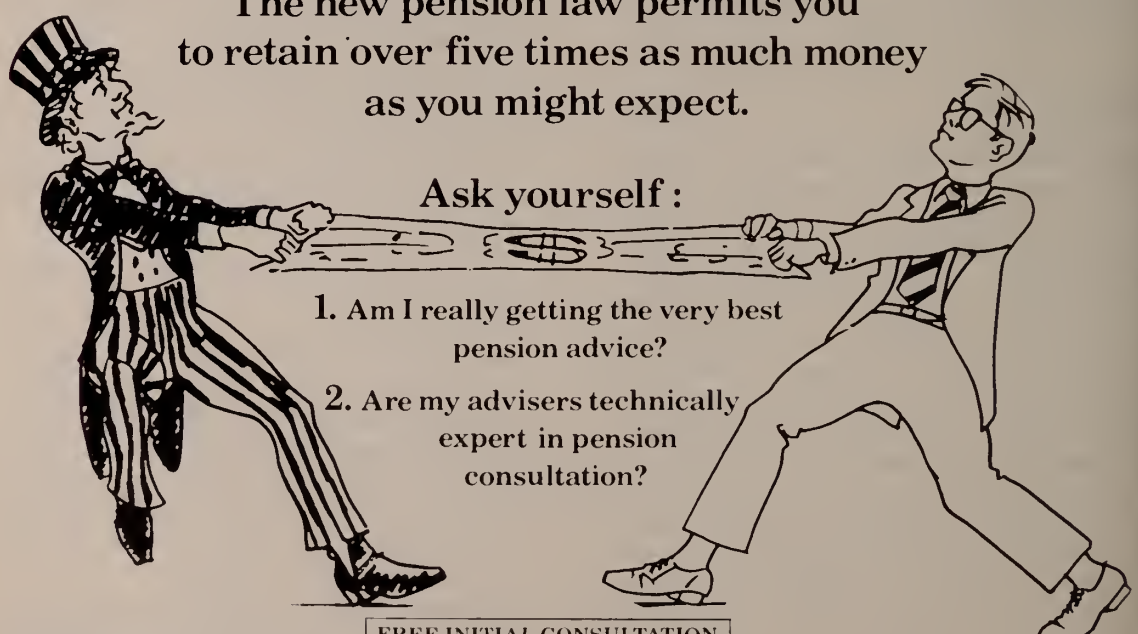
*The author is indebted to R. A. Seeler, M.D. and N. Jacobs, M.D. for helpful suggestions in the preparation of the manuscript.*


### References


1. Kawasaki, T.: "Mucocutaneous Lymph Node Syndrome: Clinical Observation of 50 Cases," *Jap. J. Allergol.*, 16:178-222, 1967.
2. Melish, M. E., Hicks, R. M., Larson, E.: "Mucocutaneous Lymph Node Syndrome (MLNS) in the U.S., Abstracted," *Pediatric Res.*, 8:427, 1974.
3. Yanagisawa, M., Kobayashi, N., Matsuya, S.: "Myocardial Infarction due to Coronary Thromboarteritis following Acute Febrile Mucocutaneous Lymph Node Syndrome in an Infant," *Ped.*, 54:277-281, 1974.
4. Radford, D. J., Sondheimer, H. M., Williams, G. J., Fowler, R. S.: "Mucocutaneous Lymph Node Syndrome with Coronary Artery Aneurysm," *Am. J. Dis. Child.*, 130:596-598, 1976.
5. Brewer, E. J., Jr., Bass, J. C., Cassidy, J. T., *et al.*: "Criterial for Classification of JRA," *Bull. Rheumatic Dis.*, 23:712-719, 1973.
6. Melish, M. E., Hicks, R. M., Larson, E. J.: "Mucocutaneous Lymph Node Syndrome in the U.S.," *Am. J. Dis. Child.*, 130:599-607, 1976.
7. John, T. J., DeBenedetti, C., Lee, M. L.: "Mucocutaneous Lymph Node Syndrome in Arizona," *Am. J. Dis. Child.*, 130:613-614, 1976.
8. Lauer, B. A., Bruhm, F. W., Todd, J. K., Todd, W. A.: "Mucocutaneous Lymph Node Syndrome in Denver," *Am. J. Dis. Child.*, 130:610-612, 1976.
9. Riley, H. D.: "Editorial on Mucocutaneous Lymph Node Syndrome," *J. Infect. Dis.*, 134:302-304, 1976.
10. Bergeson, P. S., Schoenike, S. L.: "Mucocutaneous Lymph Node Syndrome," *JAMA*, 237:2299-2302, 1977.
11. Unsigned editorial: "Kawasaki Disease," *Lancet*, 1:675-676, 1976.



The new pension law permits you to retain over five times as much money as you might expect.




FREE INITIAL CONSULTATION

American Society Pension Actuaries
Consultants to the Chicago Medical Society Employees Pension Plan
National Association Pension Consultants

Mann, Levine & Weiss, Ltd. 3525 W. Peterson, Chicago, IL 60659

(312) 539-7820 Pension Consultants and Plan Designers (312) 539-7820

# Doctor's News

**MALPRACTICE UPDATE**—A malpractice suit involving Chicago physician John O'Donoghue, Jr., M.D., Edith Widder, M.D. and Edward J. Winter, M.D., had brought awards totalling $2,500,000 in the initial trial. Doctor O'Donoghue alone chose to appeal after a remittitur, and the original decision against him was reversed by the Illinois Court of Appeals. The Illinois Supreme Court refused certiorari late in January, effectively exhonerating Doctor O'Donoghue.

**JCAH SEEKS PHYSICIAN-SURVEYORS**—The Joint Commission on Accreditation of Hospitals is recruiting physician surveyors for its Hospital Accreditation Program. Physician surveyors are responsible for on-site review of medical staff functions, departments and services. Applicants must be currently licensed with broadly based clinical backgrounds and extensive experience in hospital medical staff practices. For further information contact JCAH at 875 N. Michigan Avenue, Chicago 60611, or telephone (312) 642-6061.

**FAMILY DYNAMICS WORKSHOPS ANNOUNCED**—The Menninger Foundation will hold two workshops for "Physicians and Their Families" in Estes Park, Colorado, this summer. On June 18-23 and again August 13-18, physicians will have the opportunity to study family dynamics and stages of growth. The program is approved for 25 prescribed AAFP continuing education hours. It is also accredited by the AMA for 25 hours of Category 1 credit. For further information, contact The Menninger Foundation, Box 829, Topeka, Kansas 66601.

**BYLAWS INTERPRETATION**—In a recent memo to County Medical Society Secretaries, Robert T. Fox, M.D., chairman of the ISMS Board of Trustees, provided a helpful interpretation of Chapter XI, Discipline, Part I of the ISMS By-laws, entitled Component Society Procedure, Section 6, Verdict.

The bylaws provide that if a county society hearing body finds a member guilty of unethical conduct it shall "recommend censure, suspension or expulsion."

The Board, asked to determine whether this meant suspension of membership or of privileges, determined that the latter was intended. This allows a physician to remain a dues-paying member with the right to receive all county society, ISMS and AMA publications and to participate in their respective insurance programs. However, it would prohibit him from holding office, voting on Society issues or participating in the governance of his county, state and national societies.

**INTRAV TRIP RESCHEDULED**—The Imperial Europe Adventure to Austria, Hungary and Yugoslavia, formerly scheduled to depart on August 30 and return on September 9, has been rescheduled. Please note that the trip will now depart on September 2, 1978 and return on September 12, 1978.

**PHYSICIANS IN THE NEWS**—**Harold A. Sofield, M.D.,** Oak Park, was recently elected vice president of the American Retired Physicians Association. . . . **Morris J. Hoffman, M.D.,** Oak Park, was recently honored by the medical staff at Oak Park Hospital for fifty years of medical practice. Doctor Hoffman was 1961 president of the Oak Park Hospital medical staff. . . .

**Walter J. Kawula, M.D.,** Lake Forest, **Anthony K. Sapienza, M.D.,** Oak Lawn, **Robert T. Swastek, M.D.,** Chicago, **Raymond J. Pellicore, M.D.,** Chicago and **Anthony B. Vacante, M.D.,** Chicago, are the first five physicians inducted into the Loyola University Chapter of Phi Delta Kappa, a professional education fraternity. Each is a member of the medical staff at St. Mary of Nazareth Hospital Center in Chicago. . . .

The Chicago Society of Plastic Surgery has elected 1978 officers. Chicago physicians **Stuart J. F. Landa, Martin C. Robson** and **Norman E. Hugo** were elected president, vice president and treasurer, and Skokie physician **Richard L. Sperling** will serve as secretary. . . . The Chicago Medical Society's first annual Public Service Award was given to **Robert R. Mustell, M.D.,** Chicago on March 15. Doctor Mustell received the ISMS "Doctor of the Year" award in 1957.

**CHILD ABUSE CONFERENCE SCHEDULED**—Illinois Governor James R. Thompson has announced that a governor's conference on prevention of child abuse will be held at the Chicago Pick Congress Hotel May 10-12, 1978. Featured speakers will include Rowine Hayes Brown, M.D., medical director of Cook County Hospital. The conference is held in cooperation with the Illinois Chapter of the National Committee for the Prevention of Child Abuse. Further information is available from the Committee through Sue Lenart, 111 E. Wacker Drive, Chicago, 60601 (312) 565-1100.

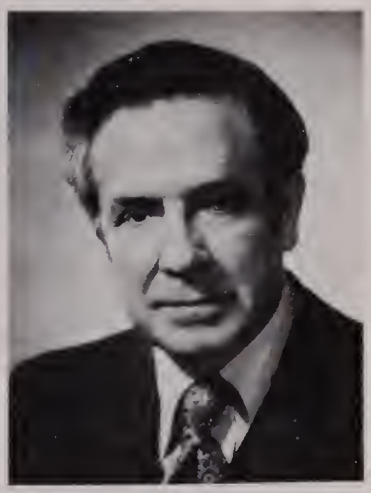
**OPHTHALMOLOGIST'S ANNUAL MEETING ANNOUNCED**—Carl Garfinkle, M.D., president, Illinois Association of Ophthalmology, recently announced that the Association's Annual Meeting will be held Friday, May 26, Drake Hotel, Chicago at 4:30 p.m. The meeting will be held in conjunction with the Chicago Ophthalmological Society annual scientific presentations.

The featured speaker will be Robert Wilmoth, a Detroit attorney well-known for his interest in ophthalmological issues. Mr. Wilmoth, legal counsel for the Michigan Ophthalmological Society, is author of the widely-distributed monograph, "The Future of Ophthalmology." Addressing the topic, "The Survival of Ophthalmology," Mr. Wilmoth will focus on recent legislative and regulatory incursions into ophthalmological practices.

**HEART ATTACKS STUDIED**—The University of Chicago has reported a new hope for potential heart attack victims. Their study employs small cassette tape recorders carried by volunteer patients, which record irregular heart beats and feed data into a central computer for physician analysis. In addition to other irregularities, the data will be particularly useful in detecting preventricular beats. These will be studied in terms of prematurity, source (right or left side of the heart), bigeminy, and severity.

The study is conducted by Harry A. Fozzard, M.D., joint director of the cardiology section and director of the biomedical computation center in the division of biological sciences, Pritzker School of Medicine.

## *President's Page*



# TIME WELL SPENT

During recent conversations with several Illinois Congressmen, it became evident that they hold individual members of our profession in high esteem. However, their attitude toward the profession as a whole was alarming. Collectively, physicians still are viewed as obstructionists who are moved only by matters of self interest or threats to their "turf."

Physicians have been complaining about this misconception for a long time. Unfortunately, most of our complaining has been done in the company of other physicians. And time spent talking to each other is not always time well spent.

Instead, physicians must communicate their views to the public. Only through better communication can we hope to improve the public's perception of our profession. We must be willing to spend the time necessary to talk to our patients. We also must communicate our concerns to state and national legislators . . . and back up our words with support for IMPAC and AMPAC.

The efforts of the AMA's National Commission on the Cost of Medical Care and the ISMS Task Force on Cost Effectiveness are a step in the right direction. Communicating the profession's attempts to contain rising medical costs hopefully will help convince the public of our concern for its well-being.

However, our cost containment program is only one of many messages that must be carried to the public and the legislators. As I enter my term as ISMS president, I pledge to intensify the Society's campaign to improve the profession's image. I ask each ISMS member to join me in this endeavor.

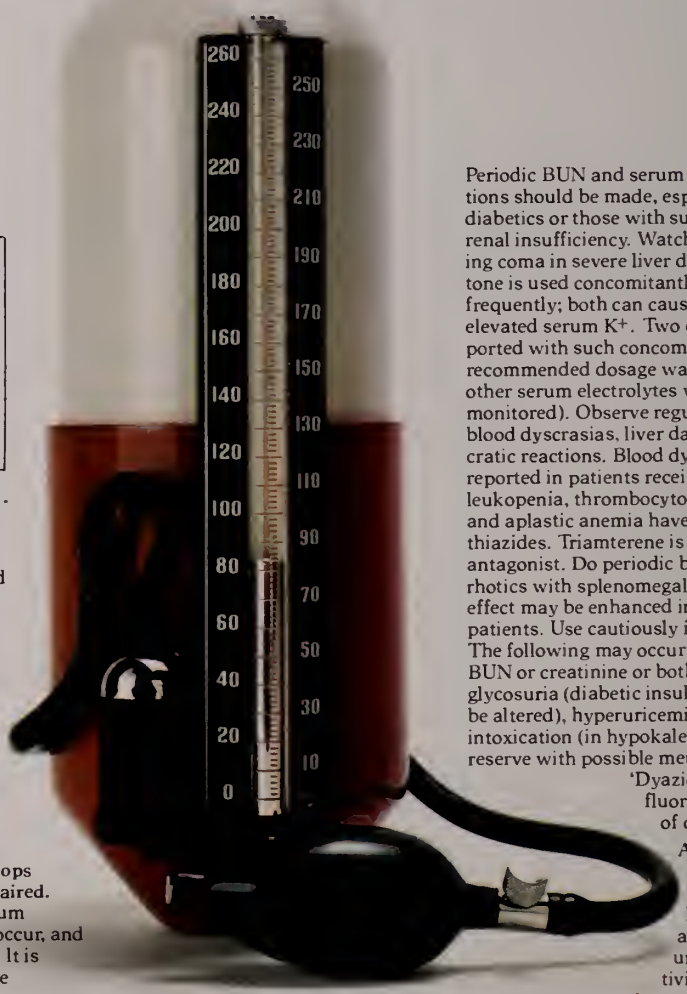
David S. Fox, M.D., President

# TRIAMTERENE CONSERVES POTASSIUM WHILE HYDROCHLOROTHIAZIDE LOWERS BLOOD PRESSURE

# DYAZIDE®

Each capsule contains 50 mg. of Dyrenium® (triamterene, SK&F Co.) and 25 mg. of hydrochlorothiazide.

## MAKES SENSE




Before prescribing, see complete prescribing information in SK&F Co. literature or PDR. A brief summary follows:

* Warning
This drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual. If this combination represents the dosage so determined, its use may be more convenient in patient management. Treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

* **Indications:** When the combination represents the dosage determined by titration: Adjunctive therapy in edema associated with congestive heart failure, hepatic cirrhosis, the nephrotic syndrome. Corticosteroid and estrogen-induced edema, idiopathic edema; hypertension, when the potassium sparing action of triamterene is warranted. (See Box Warning.) Routine use of diuretics in healthy pregnant women is inappropriate; they are indicated in pregnancy only when edema is due to pathological causes.

**Contraindications:** Further use in anuria, progressive renal or hepatic dysfunction, hyperkalemia. Pre-existing elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs.

**Warnings:** Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired. If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in the severely ill, with urine volume less than one liter/day, the elderly and diabetics with suspected or confirmed renal insufficiency. Periodically, serum $K^+$ levels should be determined. If hyperkalemia develops, substitute a thiazide alone, restrict $K^+$ intake. Associated widened QRS complex or arrhythmia requires prompt additional therapy. Thiazides cross the placental barrier and appear in cord blood. Use in pregnancy requires weighing anticipated benefits against possible hazards, including fetal or neonatal jaundice, thrombocytopenia, other adverse reactions seen in adults. Thiazides appear and triamterene may appear in breast milk. If their use is essential, the patient should stop nursing. Adequate information on use in children is not available.

**Precautions:** Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Watch for signs of impending coma in severe liver disease. If spironolactone is used concomitantly, determine serum K frequently; both can cause $K^+$ retention and elevated serum $K^+$. Two deaths have been reported with such concomitant therapy (in one, recommended dosage was exceeded, in the other serum electrolytes were not properly monitored). Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with thiazides. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effect may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine.

**Adverse Reactions:** Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions, nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances. Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and, rarely, allergic pneumonitis have occurred with thiazides alone.

**Supplied:** Bottles of 100 and 1000 capsules. Single Unit Packages of 100 (intended for institutional use only).

**FOR LONG-TERM CONTROL OF HYPERTENSION.* SERUM $K^+$ AND BUN SHOULD BE CHECKED PERIODICALLY. (SEE WARNINGS SECTION.)**

SK&F CO., Carolina, P.R. 00630

SK&F CO
a SmithKline compan

# Awake on the job, yet anxieties resolved



## Troublesome drowsiness uncommon

Tranxene lets you manage anxiety in most patients without problem sedation. Any initial drowsiness is usually transient.

## Calming without impairment

Patients not oversedated can function better on the job*or at home. By avoiding excessive sedation, Tranxene helps you calm patients without compromising their capacities.

**Tranxene®**
(CLORAZEPATE DIPOTASSIUM)

CIV

4306CB

*Of course patients should be cautioned against hazardous tasks requiring mental alertness. See overleaf for prescribing information.

ABBOTT

8033249R

# Tranxene® (IV)

(CLORAZEPATE DIPOTASSIUM) 4306CB

CAPSULES,
SINGLE DOSE TABLETS

**Brief Summary**

**ACTIONS** — Pharmacologically, clorazepate dipotassium has the characteristics of the benzodiazepines. It has depressant effects on the central nervous system. The primary metabolite, nordiazepam, quickly appears in the blood stream. The serum half-life is about 2 days. The drug is metabolized in the liver and excreted primarily in the urine. (See CLINICAL PHARMACOLOGY section.)

**INDICATIONS** — TRANXENE is indicated for the symptomatic relief of anxiety associated with anxiety neurosis, in other psychoneuroses in which anxiety symptoms are prominent features, and as an adjunct in disease states in which anxiety is manifested.

TRANXENE is indicated for the symptomatic relief of acute alcohol withdrawal.

The effectiveness of TRANXENE in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should reassess periodically the usefulness of the drug for the individual patient.

**CONTRAINDICATIONS** — TRANXENE is contraindicated in patients with a known hypersensitivity to the drug, and in those with acute narrow angle glaucoma.

**WARNINGS** — TRANXENE is not recommended for use in depressive neuroses or in psychotic reactions.

Patients on TRANXENE should be cautioned against engaging in hazardous occupations requiring mental alertness, such as operating dangerous machinery including motor vehicles.

Since TRANXENE has a central nervous system depressant effect, patients should be advised against the simultaneous use of other CNS-depressant drugs, and cautioned that the effects of alcohol may be increased.

Because of the lack of sufficient clinical experience, TRANXENE is not recommended for use in patients less than 18 years of age.

*Physical and Psychological Dependence:*

Withdrawal symptoms (similar in character to those noted with barbiturates and alcohol) have occurred following abrupt discontinuance of clorazepate. Symptoms of nervousness, insomnia, irritability, diarrhea, muscle aches and memory impairment have followed abrupt withdrawal after long-term use of high dosage.

Caution should be observed in patients who are considered to have a psychological potential for drug dependence.

Evidence of drug dependence has been observed in dogs and rabbits which was characterized by convulsive seizures when the drug was abruptly withdrawn or the dose was reduced, the syndrome in dogs could be abolished by administration of clorazepate.

*Usage in Pregnancy:*

**An increased risk of congenital malformations associated with the use of minor tranquilizers (chlordiazepoxide, diazepam, and meprobamate) during the first trimester of pregnancy has been suggested in several studies. TRANXENE, a benzodiazepine derivative, has not been studied adequately to determine whether it, too, may be associated with an increased risk of fetal abnormality. Because use of these drugs is rarely a matter of urgency, their use during this period should almost always be avoided. The possibility that a woman of childbearing potential may be pregnant at the time of institution of therapy should be considered. Patients should be advised that if they become pregnant during therapy or intend to become pregnant they should communicate with their physician about the desirability of discontinuing the drug.**

*Usage during Lactation:*

TRANXENE should not be given to nursing mothers since it has been reported that nordiazepam is excreted in human breast milk.

**PRECAUTIONS** — In those patients in which a degree of depression accompanies the anxiety, suicidal tendencies may be present and protective measures may be required. The least amount of drug that is feasible should be available to the patient.

Patients on TRANXENE for prolonged periods should have blood counts and liver function tests periodically. The usual precautions in treating patients with impaired renal or hepatic function should also be observed.

In elderly or debilitated patients, the initial dose should be small, and increments should be made gradually, in accordance with the response of the patient, to preclude ataxia or excessive sedation.

**ADVERSE REACTIONS** — The side effect most frequently reported was drowsiness. Less commonly reported (in descending order of occurrence) were: dizziness, various gastrointestinal complaints, nervousness, blurred vision, dry mouth, headache, and mental confusion. Other side effects included insomnia, transient skin rashes, fatigue, ataxia, genitourinary complaints, irritability, diplopia, depression and slurred speech.

There have been reports of abnormal liver and kidney function tests and of decrease in hematocrit.

Decrease in systolic blood pressure has been observed.

**DOSAGE AND ADMINISTRATION**

*For the symptomatic relief of anxiety:*

TRANXENE is administered orally. The capsules may be given in divided doses. The usual daily dose is 30 mg. The dose should be adjusted gradually within the range of 15 to 60 mg. daily in accordance with the response of the patient. In elderly or debilitated patients it is advisable to initiate treatment at a daily dose of 7.5 to 15 mg.

TRANXENE capsules may also be administered as a single dose daily at bedtime; the recommended initial dose is 15 mg. After the initial dose, the response of the patient may require adjustment of subsequent dosage. Lower doses may be indicated in the elderly patient. Drowsiness may occur at the initiation of treatment and with dosage increment.

TRANXENE-SD tablets (22.5 mg.) may be administered as a single dose every 24 hours. This tablet is intended as an alternate dosage form for the convenience of patients stabilized on a dose of 7.5 mg. capsules three times a day. TRANXENE-SD tablets should not be used to initiate therapy.

TRANXENE-SD HALF STRENGTH tablets (11.25 mg.) may be administered as a single dose every 24 hours.

*For the symptomatic relief of acute alcohol withdrawal:*

Recommended schedule: 1st 24 hours, 30 mg. TRANXENE initially, followed by 30 to 60 mg. in divided doses; 2nd 24 hours, 45 to 90 mg. in divided doses; 3rd 24 hours, 22.5 to 45 mg. in divided doses; 4th day, 15 to 30 mg. in divided doses. Thereafter gradually reduce to 7.5 to 15 mg. daily, and discontinue as soon as condition is stable. Maximum daily dose is 90 mg. Avoid excessive reductions in total drug on successive days.

**DRUG INTERACTIONS** — If TRANXENE is to be combined with other drugs acting on the central nervous system, careful consideration should be given to the pharmacology of the agents to be employed. Animal experience indicates that TRANXENE prolongs the sleeping time after hexobarbital or alter ethyl alcohol, increases the inhibitory effects of chlorpromazine, but does not exhibit monoamine oxidase inhibition. Clinical studies have shown increased sedation with concurrent hypnotic medications. The actions of the benzodiazepines may be potentiated by barbiturates, narcotics, phenothiazines, monoamine oxidase inhibitors or other antidepressants.

If TRANXENE is used to treat anxiety associated with somatic disease states, careful attention must be paid to possible drug interaction with concomitant medication.

**MANAGEMENT OF OVERDOSAGE** — Overdosage is usually manifested by varying degrees of CNS depression ranging from slight sedation to coma. As in the management of overdosage with any drug, it should be borne in mind that multiple agents may have been taken.

There are no specific antidotes for the benzodiazepines. The treatment of overdosage should consist of the general measures employed in the management of overdosage of any CNS depressant. Gastric evacuation either by the induction of emesis, lavage, or both, should be performed immediately. General supportive care, including frequent monitoring of the vital signs and close observation of the patient, is indicated. Hypotension, though rarely reported, may occur with large overdoses. In such cases the use of agents such as Levophed® (levarterenol) or Aramine® (metaraminol) should be considered.

While reports indicate that individuals have survived overdoses of TRANXENE (clorazepate dipotassium) as high as 450 to 675 mg., these doses are not necessarily an accurate indication of the amount of drug absorbed since the time interval between ingestion and the institution of treatment was not always known. Sedation in varying degrees was the most common physiological manifestation of TRANXENE overdosage. Deep coma when it occurred was usually associated with the ingestion of other drugs in addition to TRANXENE.

**CLINICAL PHARMACOLOGY** — Studies in healthy men have shown that TRANXENE has depressant effects on the central nervous system. Prolonged administration of single daily doses as high as 120 mg. was without toxic effects. Abrupt cessation of high doses was followed in some patients by nervousness, insomnia, irritability, diarrhea, muscle aches and memory impairment.

*Absorption — Excretion.*

After oral administration of TRANXENE, there is essentially no circulating parent drug. Nordiazepam, its primary metabolite, quickly appears in the blood stream. In 2 volunteers given 15 mg. (50 $\mu$C) of $^{14}$C-TRANXENE, about 80% was recovered in the urine and feces within 10 days. Excretion was primarily in the urine with about 1% excreted per day on day 10.

**HOW SUPPLIED** — TRANXENE (clorazepate dipotassium) is supplied as capsules in three dosage strengths:

3.75 mg. capsules (gray with white cap) in bottles of 100 (NDC 0074-3417-13) and 500 (NDC 0074-3417-53). Also available in ABBO-PAC® unit dose packages of 100 capsules (NDC 0074-3417-11).

7.5 mg. capsules (gray with maroon cap) in bottles of 30 (NDC 0074-3418-30), 100 (NDC 0074-3418-13) and 500 (NDC 0074-3418-53). Also available in ABBO-PAC unit dose packages of 100 capsules (NDC 0074-3418-11).

15 mg. capsules (all gray) in bottles of 100 (NDC 0074-3419-13) and 500 (NDC 0074-3419-53). Also available in ABBO-PAC unit dose packages of 100 capsules (NDC 0074-3419-11).

TRANXENE-SD single dose tablets are supplied in two dosage strengths:

TRANXENE-SD 22.5 mg. tablets (tan-colored) in bottles of 100 (NDC 0074-2997-13).

TRANXENE-SD HALF STRENGTH 11.25 mg. tablets (blue-colored) in bottles of 30 (NDC 0074-2699-30) and 100 (NDC 0074-2699-13).

803324

# *Viewbox*

*(Continued from page 264)*



**Figure 2**

**DIAGNOSIS: PERFORATED UTERUS**

A right lower quadrant mass or dilated right lower quadrant bowel loops would suggest either diagnosis (2) or (4). The presence of an appendicolith would also be very helpful for the diagnosis of appendicitis. None of these findings are present. The presence of a non-dilated colon excludes (3).

The key to diagnosis is the distorted shape of the Lippe's loop intrauterine device. This type of IUD should form tight coils when bound down by the uterine wall (as shown in Figure 2). This distance between the loops should not be greater than 1 centimeter. If the IUD has been extruded outside of the uterus, then the compressing effect of the uterus is lost and the S-shaped springs open. This may occur with either complete or partial extrusion through the uterine wall. Figure 1 shows the distortion of the IUD with a wide distance between the bulb and the first loop. The other loops appear normal. Gynecologic examination revealed a tender right adnexa and tender right posterior uterine wall. The IUD was partially intrauterine and was removed vaginally with difficulty. The patient was much improved the following day and discharged one day after that. Subsequently, she was without symptoms. The IUD had been inserted at another institution about two months prior to the onset of symptoms.

It is estimated that between 1/1,000 and 1/2,500 IUDs perforate the uterus—probably at the time of insertion. Eisenberg reports four cases of IUDs perforating uteruses in which three of the pations were asymptomatic and one had back pain. These cases were discovered from two weeks to fifteen months following insertion.

The roentgenographic picture of a "sprung" Lippe's loop IUD is evidence that the IUD is no longer completely intrauterine. This may be substantiated with hysterosalpingography or ultrasound.

**References**

Eisenberg, R. L.: "The widened loop sign of Lippe's loop perforations," *Am. J. Roent. Rad. Therapy, Nuc. Med.*, 116:847-852, 1972.

Hall, R. E.: "Comparative evaluation of intrauterine devices," *Am. J. Obstet., Gynecol.*, 94:65-71, 1965.

Tietze, C.: "Comparative statistical project of the evaluation of intrauterine conceptive devices," National Committee on Maternal Health: 6th Progress Report, Part 1. New York, December 31, 1965.

LIBRARY
MAY 8 1978
NEW YORK ACADEMY OF MEDICINE

IMJ
Illinois Medical Journal

# YOUR ADVERTISERS

*Our advertisers serve the Medical Profession and support your Journal. All advertisers are approved by your Journal Committee. It will help you and your society to mention your Journal when writing them.*

## Space Representatives

United Media Associates, Inc., 16 Bruce Park Avenue, Greenwich, Conn. 06830

## Pharmaceuticals


333-334 Abbott Laboratories
*Tranxene*

268-269 Bristol Laboratories
Div. of Bristol-Myers Co.
*Tegopen*

Cover 2 Burroughs Wellcome Company
*Neosporin*

266-267 Burroughs Wellcome Company
*Cardilate*

274 Eli Lilly and Company
*Kefzol*

271-272 Geigy Pharmaceuticals
Div. of Ciba-Geigy Corp.
*Tofranil—P.M.*

301-304 Mead Johnson Laboratories
*Colace*
*Quibron*

262-263 Merck Sharp and Dohme, Inc.
*Hydrodiuril*

255-256 Roche Laboratories
Div. of Hoffman-LaRoche
*Librax*

Covers 3&4 Roche Laboratories
Div. of Hoffman-LaRoche
*Librium*

332 Smith Kline and French Labs.
Div. of SmithKline Corp.
*Dyazide*

277 Upjohn Pharmaceuticals
*Tolinase*

257 Warren Teed Laboratories
*Kaon*

261 Warren Teed Laboratories
*Modane*


## Insurance


291 Medical Protective Co.
*Professional Liability Ins.*

320 Parker Aleshire and Co.
*Group Insurance*


## Services and Continuing Education


321 American Medical Association
*Annual Meeting*

259-260 Blue Cross and Blue Shield
Report

322-323 Classified Advertising

323 Clover Leaf Towers
*Office Space*

308 Cook County Graduate School
*Continuing Medical Education*

316-317 Illinois Council on Continuing
Medical Education

275 INTRAV
*Imperial Europe Adventure*

328 Mann, Levine & Weiss
*Pension Consultants*

273 Medical World News

281 Oak Forest Hospital
*Resident Programs*

311 Oak Forest Hospital
*General Surgeon Wanted*

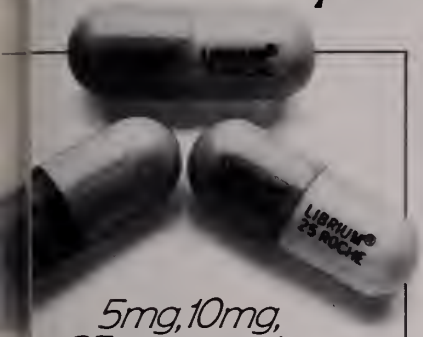
287 O'Hare Autos
*Leasing Service*

313 Park West Medical Plaza
*Office Space*

324-325 Pharmaceutical Manufacturers
Association
*Patient Package Inserts*

280 Practice Productivity, Inc.
*Workshop*

# Librium®
## chlordiazepoxide HCl/Roche




5mg, 10mg, 25mg capsules

- ☐ Proven antianxiety performance
- ☐ An unsurpassed safety record
- ☐ Predictable patient response
- ☐ Minimal effect on mental acuity at recommended doses
- ☐ Minimal interference with many primary medications, such as antacids, anticholinergics, diuretics, cardiac glycosides and antihypertensive agents

**efore prescribing, please consult complete product information, a summary of which follows:**

**Indications:** Relief of anxiety and tension occurring alone or accompanying various disease states. Efficacy beyond four months not established by systematic clinical studies. Periodic reassessment of therapy recommended.

**Contraindications:** Patients with known hypersensitivity to the drug.

**Warnings:** Warn patients that mental and/or physical abilities required for tasks such as driving or operating machinery may be impaired, as may be mental alertness in children; and that concomitant use with alcohol or CNS depressants may have an additive effect. Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported.

**Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

**Precautions:** In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotherapeutic agents seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

**Adverse Reactions:** Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

**Usual Daily Dosage:** Individualize for maximum beneficial effects. Oral—Adults: Mild and moderate anxiety and tension, 5 or 10 mg t.i.d. or q.i.d.; severe states, 20 or 25 mg t.i.d. or q.i.d. Geriatric patients: 5 mg b.i.d. to q.i.d. (See Precautions.)

**Supplied:** Librium® (chlordiazepoxide HCl) Capsules, 5 mg, 10 mg and 25 mg—bottles of 100 and 500; Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10; Prescription Paks of 50, available singly and in trays of 10. Libritabs® (chlordiazepoxide) Tablets, 5 mg, 10 mg and 25 mg—bottles of 100 and 500. With respect to clinical activity, capsules and tablets are indistinguishable.

## Synonymous with relief of anxiety

ROCHE

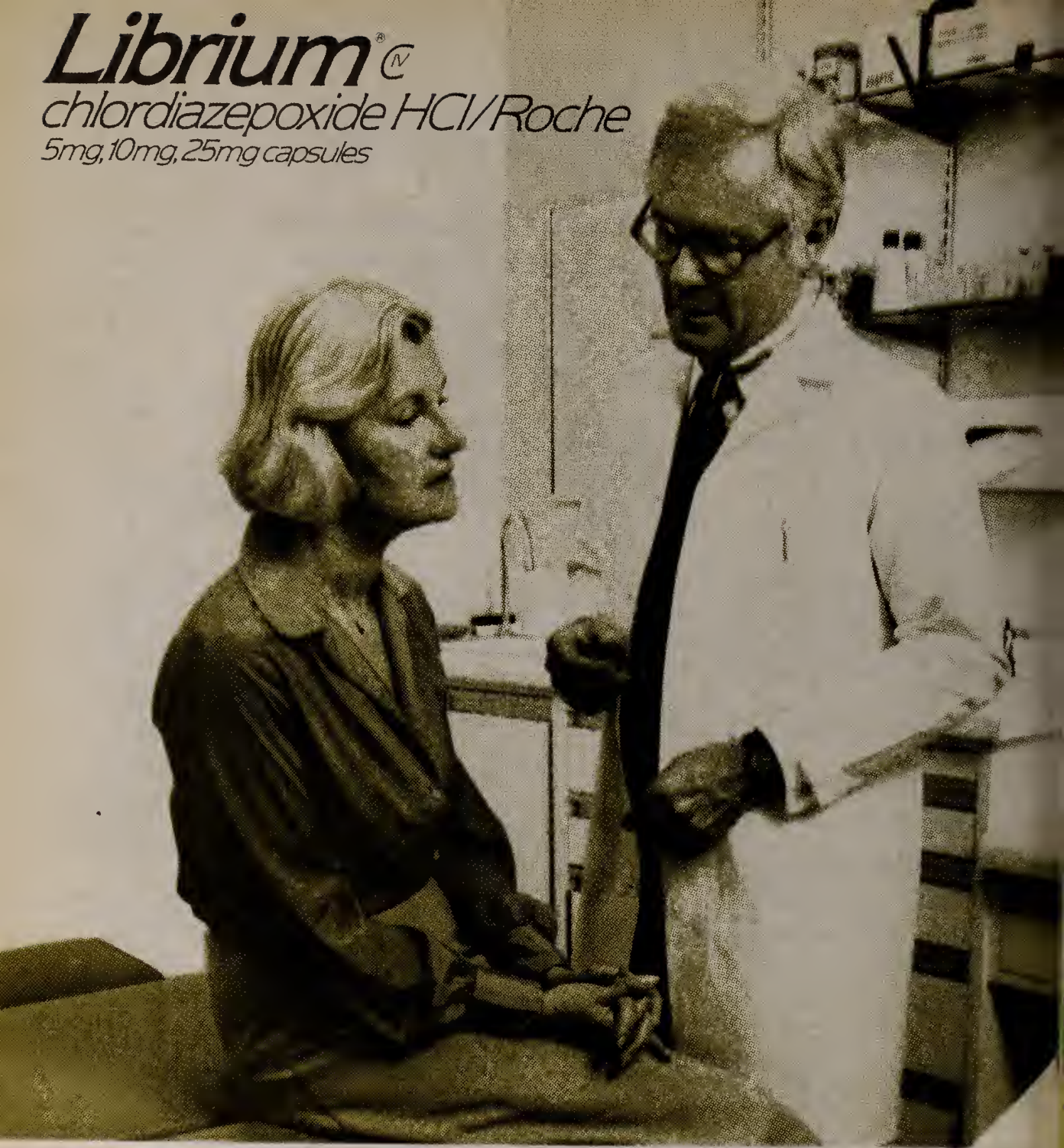
Roche Products Inc.
Manati, Puerto Rico 00701

**Please see following page.**

# Librium®Ⓒ IV

chlordiazepoxide HCl/Roche

5mg, 10mg, 25mg capsules



synonymous with relief of anxiet

ROCHE

Please see preceding page for a summary of product information.

BALCONY

# Illinois Medical Journal

OFFICIAL JOURNAL OF THE
ILLINOIS STATE MEDICAL SOCIETY



David S. Fox, *President*



P. John Seward, *President-Elect*

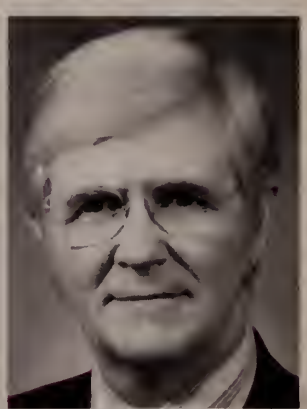


Robert R. Hartman, *Chairman of the Board*

## 1978-79 Officers



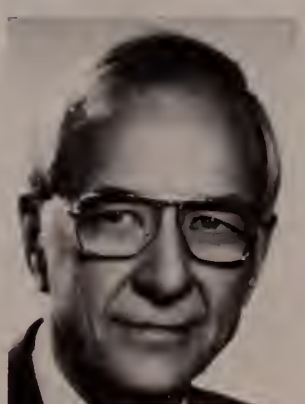
Cyril C. Wiggishoff,
*Speaker of the House*



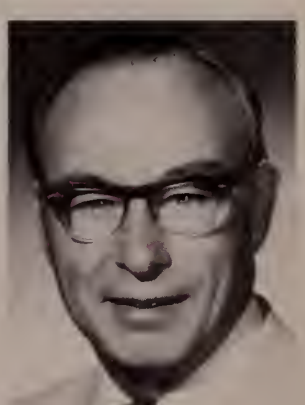
Robert P. Johnson,
*Vice Speaker of the House*



Audley F. Connor, *Secretary-Treasurer*



Herschel Browns, *First Vice President*



G. W. Giebelhausen, *Second Vice President*

NEW YORK ACADEMY OF MEDICINE
LIBRARY, PERIODICAL DEPARTMENT
2 EAST 103RD STREET

53, Number 5, May 1978

s Page .....415
Contents .....337

Convention Summary . . . 365




# EMPIRIN® COMPOUND
# with CODEINE

Each tablet contains aspirin 227 mg, phenacetin 162 mg and caffeine 32 mg, plus codeine phosphate in one of the following strengths: #4—60 mg (gr 1) #3—30 mg (gr ½) #2—15 mg (gr ¼) and #1—8 mg (gr ⅛) (Warning—may be habit forming.)

C III

Burroughs Wellcome Co.
Research Triangle Park
North Carolina 27709

IMJ

Illinois Medical Journal

MAY, 1978 Vol. 153, No. 5 CONTENTS

342 Abstracts of Board of Trustees Actions

*Clinical Articles*

359 Impact of Community Mental Health Programs on Hospitalization for Mental Illness: An Historical Perspective
*By William G. Smith, M.D., Margaret Krzyzanowski, B.A., and Randall Heinemann, M.A.P.A./Rockford*

*Convention Summary*

366 1978-79 Officers and Board of Trustees

367 Highlights of the 1978 Annual Meeting

377 Summary of House of Delegates Actions

381 Actions on Resolutions

*President's Page*

415 The Cost Challenge
*David S. Fox, M.D.*

*(Contents continued on overleaf)*

## *Features*


341 Clinics for Crippled Children
345 Editorial
351 Obituaries
352 Viewbox
356 EKG of the Month
364 New Pharmaceutical Specialties
396 Pulse of the ISMS Auxiliary
402 Physician Recruitment
408 ISMS Guide to Continuing Medical Education
410 Classified Advertising
412 Illinois Society, American Association of Medical Assistants
413 Doctor's News
416 Membership Forum


## *Staff*


**Managing Editor** ..... **Richard A. Ott**
**Assistant Editor** ..... **Mariann M. Stephens**
**Executive Administrator** ..... **Roger N. White**

*(Cover by Richard A. Ott)*

**PUBLICATIONS COMMITTEE**
Lawrence L. Hirsch, M.D., Chicago, *Chairman*
Kenneth A. Hurst, M.D., Naperville
Robert P. Johnson, M.D., Springfield
Alfred J. Kiessel, M.D., Decatur

**Editorial Board**
J. William Roddick, Jr., M.D., *Chairman*
Eli L. Borkon, M.D., Carbondale
Daniel R. Cunningham, M.D., Wilmette
Raymond A. Dieter, Jr., M.D., Glen Ellyn
James G. Ekeberg, M.D., Palatine
Ediz Z. Ezdinli, M.D., Kenilworth
Carl Neuhoff, M.D., Peoria
Constantine S. Soter, M.D., Arlington Heights
Donald D. VanFossan, M.D., Springfield

Contributor in Surgery: John M. Beal, M.D., Chicago
Contributor in Maternal Death Studies:
Robert R. Hartman, M.D., Jacksonville
Contributor in Pediatric Perplexities: Ruth Andrea Seeler, M.D., Chicago
Contributor in Radiology: Leon Love, M.D., Maywood
Contributor in Cardiology: John R. Tobin, M.D., Maywood
Contributor in Immunopathology: Richard J. Ablin, Ph.D., Chicago
Contributor in Rheumatology: L. F. Layfer, M.D., Chicago


## ILLINOIS STATE MEDICAL SOCIETY


**OFFICERS**
David S. Fox, M.D., President
826 E. 61st St., Chicago 60637
P. John Seward, M.D., President-Elect
310 N. Wyman St., Rockford 61101
Herschel Browns, M.D., 1st Vice-President
4600 N. Ravenswood, Chicago 60640
G. W. Giebelhausen, M.D., 2nd Vice-President
1101 Main St., Peoria 61606
Audley F. Connor, Jr., M.D., Secretary-Treasurer
7531 S. Stony Island Ave., Chicago 60649

**HOUSE OF DELEGATES**
Cyril C. Wiggishoff, M.D., Speaker
25 E. Washington, Chicago 60602
Robert P. Johnson, M.D., Vice-Speaker
108 Maple Grove, Springfield 62707

**TRUSTEES**
1st District: 1980, John J. Ring, M.D.
511 Hawley, Mundelein 60060
2nd District: 1980, Allan L. Goslin, M.D.
712 N. Bloomington, Streator 61364
3rd District: 1979, Alfred Clementi, M.D.
675 W. Central Rd., Arlington Heights 60005
3rd District: 1980, Raymond J. Des Rosiers, M.D.
1044 N. Francisco, Chicago 60622
3rd District: 1979, Robert T. Fox, M.D.
2136 Robincrest, Glenview 60025
3rd District, 1979, Jere Freidheim, M.D.
3050 S. Wallace, Chicago 60616
3rd District: 1981, Morris T. Friedell, M.D.
7531 S. Stony Island Ave., Chicago 60649
3rd District: 1981, Henrietta Herbolsheimer, M.D.
5528 S. Hyde Park Blvd., Apt. 1202, Chicago 60637
3rd District: 1981, Lawrence L. Hirsch, M.D.
2434 Grace St., Chicago 60618
3rd District: 1980, Harold J. Lasky, M.D.
55 E. Washington, Chicago 60602
3rd District: 1980, Richard N. Rovner, M.D.
645 N. Michigan, Suite 920, Chicago 60611
3rd District: 1980, Joseph C. Sherrick, M.D.
303 E. Superior, Chicago 60611
4th District: 1979, Fred Z. White, M.D.
723 N. Second St., Chillicothe 61523
5th District: 1979, P. F. Mahon, M.D.
800 E. Carpenter, Springfield 62702
6th District: 1981, Robert R. Hartman, M.D.
1515 A. W. Walnut, Jacksonville 62650
7th District: 1979, Alfred J. Kiessel, M.D.
1 Powers Lane Pl., Decatur 62522
8th District: 1979, James Laidlaw, M.D.
104 W. Clark, Champaign 61820
9th District: 1981, Warren D. Tuttle, M.D.
203 N. Vine St., Harrisburg 62946
10th District: 1981, Julian W. Buser, M.D.
6600 W. Main St., Belleville 62223
11th District: 1980, Kenneth A. Hurst, M.D.
52 Bunting Lane, Naperville 60540
12th District: 1980, Joseph Perez, M.D.
5670 E. State St., Rockford 61108
Trustee-At-Large: George T. Wilkins, M.D.
3165 Myrtle, Granite City 62040
Chairman of the Board: Robert R. Hartman, M.D.
1515 A. W. Walnut, Jacksonville 62650



Microfilm copies of current as well as some back issues of the *Illinois Medical Journal* may be purchased from Xerox University Microfilm, 300 North Zeeb Road, Ann Arbor, Mich. 48106.

Contents of *IMJ* are listed in the *Current Contents/Clinical Practice*.

Published by the Illinois State Medical Society, 55 E. Monroe St., Chicago, Ill. 60603 (312-782-1654)



Copyright, 1978. The Illinois State Medical Society. All material subject to this copyright may be photocopied for the noncommercial purpose of scientific or educational advancement.



Subscription $8.00 per year, in advance, postage prepaid, for the United States, Cuba, Puerto Rico, Philippine Islands and Mexico. $10.00 per year for all foreign countries included in the Universal Postal Union. Canada $8.50. U.S. Single current copies available at $1.00 ($1.10 by mail), back issues $1.50.

Second class postage paid at Chicago, Ill. When moving please notify Journal office of new address including old mailing label with notification, if possible. POSTMASTER: Send notice on form No. 3579 to Illinois State Medical Society, 55 E. Monroe St., Chicago, Ill. 60603.

Pharmaceutical advertising must be approved by the ISMS Publications Committee. Other advertising accepted after review by Publications Committee or Board of Trustees. All copy or plates must reach the Journal office by the fifteenth of the month preceding publication. Rates furnished upon request.

Original articles will be considered for publication with the understanding that they are contributed only to the *Illinois Medical Journal*. The ISMS denies responsibility for opinions and statements expressed by authors or in excerpts, other than editorial or allied views or statements which reflect the authoritative action of the ISMS or of reports on official actions, policies or positions. Views expressed by authors do not necessarily represent those of the Society; any connection with official policies is coincidental.

The *Illinois Medical Journal* is published by the Illinois State Medical Society as an educational and professional informational magazine and distributed as a benefit of membership in the Illinois State Medical Society. Its intent is to keep members current in medical knowledge and is a part of a continuing medical education program. Socioeconomic matters, affecting as they do a changing pattern in the proper delivery of medical care, are considered an inherent element in medical education.




**VALIUM®(diazepam)**

**Before prescribing, please consult complete product information, a summary of which follows:**
**Indications:** Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders; athetosis; stiff-man syndrome; convulsive disorders (not for sole therapy).

**Contraindicated:** Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.
**Warnings:** Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) *Usage in Pregnancy:* **Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**
**Precautions:** If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

# Angina freedom fighter...



Freedom from anginal pain



Freedom from anginal fear

1. Taken sublingually, Cardilate® (erythrityl tetranitrate) begins to work within 5 minutes, eliminating or reducing frequency and severity of anginal pain for up to two hours.
2. Fear of pain, a major deterrent to achieving acceptable (and desirable) levels of activity, including sex, may be allayed with Cardilate. Effective prophylaxis and improved exercise tolerance help toward normalizing the lives of anginal patients.

# Cardilate®
## (erythrityl tetranitrate)

**ilate® (erythrityl tetranitrate)**
ATIONS: For the prophylaxis and long-term treat-
of patients with frequent or recurrent anginal pain
educed exercise tolerance associated with angina
ris, rather than for the treatment of the acute attack
gina pectoris, since its onset is somewhat slower
that of nitroglycerin.
AUTIONS: As with other effective nitrites, some fall
od pressure may occur with large doses.
on should be observed in administering the drug to
ts with a history of recent cerebral hemorrhage,
se of the vasodilation which occurs in the area.
ugh therapy permits more normal activity, the
t should not be allowed to misinterpret freedom
anginal attacks as a signal to drop all restrictions.
EFFECTS: No serious side effects have been
ed. In sublingual therapy, a tingling sensation (like
f nitroglycerin) may sometimes be noted at the
of tablet contact with the mucous membrane. If
tionable, this may be mitigated by placing the tablet
buccal pouch. As with nitroglycerin or other effec-
itrites, temporary vascular headache may occur
g the first few days of therapy. This can be con-
d by temporary dosage reduction in order to allow
tments of the cerebral hemodynamics to the initial
ed cerebral vasodilation. These headaches usually
pear within one week of continuous therapy but
be minimized by the administration of analgesics.
gastrointestinal disturbances occur occasionally
larger doses and may be controlled by reducing the
temporarily.
HOW SUPPLIED: 10 mg chewable scored tablets,
bottle of 100. Also 5, 10 and 15 mg oral/sublingual
scored tablets in bottles of 100. 10 mg oral/
sublingual scored tablets also supplied in bottles
of 1,000.
Also available: Cardilate®-P brand Erythrityl
Tetranitrate with Phenobarbital* Tablets
(Scored).
(*Warning—may be habit-forming.)

**Burroughs Wellcome Co.**
Research Triangle Park
North Carolina 27709

# Clinics for Crippled Children Listed for June

Thirty-five clinics for Illinois' physically handicapped children have been scheduled for June by the University of Illinois, Division of Services for Crippled Children. The Division will count twenty-five general clinics providing diagnostic orthopedic, pediatric, speech and hearing examination, along with medical social and nursing services. There will be nine special clinics for children with cardiac conditions and one for children with cerebral palsy. Any private physician may refer to or bring to a convenient clinic any child or children for whom he may want examination or consultative services.

June 1 Flora—Clay County Hospital
June 1 Sterling—Community General Hospital
June 1 Lake County Cardiac—Victory Memorial Hospital
June 1 Springfield—St. John's Hospital
June 2 Division Cardiac—U. of I. at the Medical Center
June 6 Park Ridge Cardiac—Lutheran General Hospital
June 7 Carmi—Carmi Township Hospital
June 7 Springfield Ped-Neuro—St. John's Hospital
June 7 Hinsdale—Hinsdale Sanitarium
June 7 Joliet—St. Joseph's Hospital
June 8 Kankakee General—St. Mary's Hospital
June 9 Chicago Heights Cardiac—St. James Hospital
June 12 Peoria Cardiac—St. Francis Hospital
June 13 Peoria—St. Francis Hospital
June 13 Alton—Alton Memorial Hospital
June 14 Jacksonville—Passavant Memorial Hospital
June 14 Champaign-Urbana—McKinley Hospital
June 14 Elgin MM—Sherman Hospital
June 15 West Frankfort—Union Hospital
June 15 Rockford—Swedish American Hospital
June 15 Bloomington—Mennonite Hospital
June 15 Elmhurst Cardiac—Memorial Hospital of DuPage County
June 16 Kankakee Cardiac—St. Mary's Hospital
June 19 Maywood—Loyola Medical Center
June 20 Rock Island—Moline Public Hospital
June 20 Decatur—Decatur Memorial Hospital
June 20 Belleville—St. Elizabeth's Hospital
June 21 Chicago Heights General—St. James Hospital
June 23 Evanston—St. Francis Hospital
June 23 Chicago Heights Cardiac—St. James Hospital
June 26 Peoria Cardiac—St. Francis Hospital
June 27 Peoria—St. Francis Hospital
June 27 Danville—Lake View Hospital
June 27 East St. Louis—Christian Welfare Hospital
June 28 Aurora—St. Joseph Mercy Hospital

The Division of Services for Crippled Children is the official state agency established to provide medical, surgical, corrective and other services and facilities for diagnosis, hospitalization and after-care for children with crippling conditions or who are suffering from conditions that may lead to crippling. In carrying on its program, the Division works cooperatively with local medical societies, hospitals, the Illinois Children's Hospital-School, civic and fraternal clubs, visiting nurse association, local social and welfare agencies, local chapters of the National Foundation and other interested groups. In all cases, the work of the Division is intended to extend and supplement, not supplant, activities of other agencies, either public or private, state or local, carried on in behalf of crippled children.

# *Abstracts of Board Actions*

**April 1-5, 1978** **Chicago**

## Medicaid Reimbursement

The Board endorsed a revised IDPA reimbursement system—formulated during ISMS-IDPA negotiations—that would take effect if the General Assembly approves Gov. Thompson's budget containing an additional $20 million for Medicaid payments to physicians. The $20 million increase resulted from an aggressive ISMS campaign to improve physician reimbursement levels.

Under the plan—which would take effect July 1—physicians would be reimbursed at the greater of: (1) 70% of the 1977 calendar year average statewide charge per procedure; or (2) IDPA's current statewide maximum. In no case, however, would a physician receive more than his billed charges or less than what he currently is being paid.

While falling short of prevailing UCR charges, the new system will provide some increase and should eliminate the inherent discrimination against physicians who have participated in Medicaid for many years . . . and remove variations stemming from geographic location of practices.

The Board also authorized ISMS involvement, if feasible, in a suit filed by a medical corporation based at Chicago's Michael Reese Hospital against IDPA. The suit seeks to force IDPA to recognize—for payment purposes—legally constituted medical corporations and other groups. The legal action also challenges IDPA's "one address" requirement.

In other actions concerning Medicaid, legal counsel was authorized to solicit support of the American Civil Liberties Union and appropriate welfare rights organizations in seeking a declaratory judgment—or other legal action—to resolve the confidentiality issue. Specifically, ISMS will attempt to clarify the right of a Medicaid patient to confidentiality of medical records and the corresponding right of physicians honoring that right to be free from administrative harassment.

## Monitoring System

ISMS will consider the feasibility of establishing—in cooperation with county societies—a system to identify physicians expelled from hospital staffs due to incompetence. The system would enable county societies to contact ISMS and determine if a physician applying for staff privileges in their county had been terminated from a staff in another area of the state.

## Legislation

In the current General Assembly session, ISMS will seek legislation dealing with these aspects of malpractice litigation:

*(Continued on page 393)*

Blue Cross®
Blue Shield®

# REPORT FOR *Illinois Physicians*

## New Benefit Programs Begin for United Mine Workers

Effective March 28, 1978 UMW employees of the Zeigler Coal Company in Southern Illinois are protected by a new Blue Cross and Blue Shield health care program.

The contract was the first of the new benefit programs written by Blue Cross-Blue Shield for coal mining groups in Illinois to be effective this year. Additional United Mine Workers of America groups are being enrolled in the program, effective June 1. Identification of these groups will follow in the forthcoming issues of the "Blue Cross-Blue Shield Report for Physicians."

Approximately 1,500 active employees, eligible family members and retirees are covered by the Zeigler Health Benefit Plan. The Blue Cross and Blue Shield Group Number is 45224.

The program provides Comprehensive Blue Cross coverage (365 hospital days); payment for physician services at 100% Usual and Customary; and Comprehensive Supplemental benefits.

A deductible of $7.50 per physician visit (home, office or hospital) up to a maximum of $150 per family, per calendar year ($5.00 and $100.00 for retirees, surviving spouse and dependents) is applied. In Drugs and Medications, a deductible of $5.00 per prescription applies in the purchase of prescription drugs up to a family maximum of $50 per calendar year. Also, laboratory tests in a physician's office are limited to blood counts, urinalysis, sedimentation rate, throat culture, blood sugar, blood urea nitrogen tests.

Benefits under Comprehensive Blue Cross include: full ancillary care and intensive medical care; semi-private room allowance unless condition requires private room and no semi-private room is available, and immediate occupancy is necessary; maternity care, provided pregnancy began after effective date of enrollement; care in approved Skilled Nursing Facility; and Mental, Tuberculosis, Drug and Alcoholism care.

Surgical care; accident care, if care is rendered within 24 hours; emergency medical care; diagnostic X-ray and laboratory tests; chemotherapy and radiation therapy; physiotherapy and renal dialysis when coordinated with Medicare are included in hospital outpatient benefits.

Physician services are in benefit at 100% Usual and Customary for: surgery wherever performed; hospital medical care; services of a surgical assistant when required; OB delivery including pre and post natal care; anesthesiologist services and medical consultant services.

Comprehensive supplemental benefits provide care in a Skilled Nursing Facility and include Home Health Service and equipment; orthopedic and prosthetic items: physical therapy and speech therapy; hearing aid; ambulance or other necessary transportation, autopsy charges, and prescription drugs with the deductibles.

In submitting claims for services, please use the Blue Shield Physician's Service Report form. Enter the patient's Group Number (for Zeigler employees 45224), the employee's Social Security Number and Section Number as shown on the Blue Cross-Blue Shield Membership card.

*For home and office visits, please submit the Service Reports monthly.*

When Service Reports are completed, send them to Blue Cross and Blue Shield, 233 N. Michigan Ave., Chicago, Illinois 60601, ATT: COMPREHENSIVE MAJOR MEDICAL. Special attention is being given to processing these claims. The Plan also encourages a dialogue with physicians on service aspects of the program. For answers to questions on the program, please use the Physicians' Blue Shield toll-free Hotline: 800-972-8088.

### — *Announcement* —

### GENERIC DRUG LAW EFFECTIVE JULY 1, 1978

On September 23, 1977 Governor James Thompson signed into law the Generic Drug Bill, also known as the "Drug Substitution Program." The program will become effective July 1, 1978.

The law requires that every prescription written after July 1, 1978 contain the words "May Substitute" or "May Not Substitute", with provision to check one of the two choices, and a signature line beside each. The wording should be preprinted although a rubber stamp may be used for current supplies of prescription blanks.

The prescriber must check and sign beside the preferred choice. The signature will also serve to authorize the issuance of the prescription.

The Blue Cross-Blue Shield Board urges physicians, hospitals, and other providers of service to implement the intent of the Generic Drug Law and the generic concept in the provision of service to subscribers of the Blue Cross-Blue Shield Plan.

## MEDICARE-MEDICAID BILLING

The Department of Public Aid in Springfield has asked Medicare to inform physicians that there are triplicate, or 3-ply, "Request for Medicare Payment" forms available. When submitting a Medicare form for a patient who is entitled to both Medicare and Medicaid, the triplicate, or 3-ply, forms work best.

Since Medicare is the primary insurer in the case of Medicare-Medicaid patients, the Medicare claim copy must be submitted first. Public Aid will not process a claim until the proper notice of Medicare's adjudication has been received.

When a patient is entitled to both Medicare and Medicaid benefits, the physician must accept the assignment in order to receive any payment from Public Aid for deductible and coinsurance. The Medicaid number must appear under Item 5 in the box designated "Policy or Identification Number," in order for the carrier to send an extra copy of the "Explanation of Medicare Benefits" to the physician.

After the Medicare form is completed in triplicate, the first copy should be sent to the Medicare carrier. Upon completion of processing, the payment, or notice of adjudication, will be sent to the physician. In a separate mailing, a pink "Explanation of Medicare Benefits" form will be sent to the physician for each Medicaid patient. *If there is no Medicaid number in Item 5, this pink form will not be issued.* The pink "EOMB", as it is usually referred to, must be attached to the duplicate, or second copy of the Medicare from, and sent to Public Aid. *It is not necessary to attach a Medicaid form.* The physician's AMA number should be typed, or printed clearly, and circled just to the right of his or her name in Item 8. The third copy of the Medicare form is for the physician to keep in the record, at least until payment or notice of adjudication has been received from both Medicare and Medicaid.

If, for some reason, a pink EOMB is not received, the physician should contact the Medicare carrier and a duplicate copy will be issued.

## Medicare-Medicaid Reorganization

The Department of Health, Education and Welfare has completely reorganized the administration of programs such as Medicare and Medicaid. Both programs are now under the direction of a new administration, called the Health Care Financing Administration (HCFA), with headquarters in the Department of Health, Education and Welfare (DHEW) building, Washington, D.C.

The Bureau of Health Insurance is now known as the Medicare Bureau. Although the Medicare Bureau continues to be located in Baltimore, Md., it is a part of HCFA, and is no longer a responsibility of the Social Security Administration. The Medicaid portion of HCFA is now known as the Medicaid Bureau. HCFA is headed by Robert A. Derzon, Administrator.

These organizational changes do not affect any of the present legal and procedural requirements for processing Medicare claims.

## Annual Update of Reasonable Charge

Medicare is currently in the process of the annual updating of the reasonable charge screens for physicians' and suppliers' services.

The customary and prevailing charge screens for fee screen year 1979 should be in effect for claims processed after June, 1978, unless there are problems which delay the implementation. Last year, we were unable to update the screens until August 30. Hopefully there will be no complications such as occurred last year, which delayed the effective date.

The economic index limitation on the prevailing screens will be 1.426% of prevailings in effect during fee screen year ending July 1973 (1971 base year data).

## Changes in Participation of Laboratories

Notice was received from the Medicare Bureau of the Health Care Financing Administration, concerning the following changes in participation of laboratories in the Medicare program.

**Newly Approved for Participation:**

Kendon Medical Laboratory
7101 West Archer Ave.
Chicago, Illinois 60630
Provider No. 14-8349
Effective Date: November 15, 1977

Bio-Stat Laboratory, Inc.
Eight South Michigan Ave.
Chicago, Illinois 60603
Provider No. 14-8348
Effective Date: December 1, 1977

**Closing:**

The branch facility of Mason-Barron Laboratories, Inc., Downers Grove, Illinois; Provider No. 14-8308 closed, effective February 28, 1978. No payment can be made under the health insurance program for services rendered on or after that date.

*(This report is a service to the physicians of Illinois)*

# Editorials



## IMJ Editorial Board Introduced

J. W. Roddick, Jr., M.D./Springfield

Prior to his retirement in January of 1977, Dr. Theodore Van Dellen had worked on the Illinois Medical Journal for 22 years and had served at its editor for 18 years. He almost singlehandedly screened and reviewed the scientific portions of the Journal through that entire period. Subsequent to his retirement, the ISMS Board of Trustees approved the recommendation of the Publications Committee that an Editorial Board be established for the Journal. Thus, on February 23, 1978 the first meeting of the Editorial Board of the Illinois Medical Journal took place, and initial discussions on the goals and objectives of the Journal, as well as its editorial and scientific content began. The Editorial Board consists of nine members representing seven specialties. These individuals will act as the primary panel of referees for review of manuscripts submitted for inclusion in the Journal. Since all special interest groups are not included on the Board, many others throughout the state will be asked to help in this task from time to time.

Representing Internal Medicine on the Board are Eli L. Borkon, M.D., and Ediz Z. Ezdinli, M.D. Dr. Borkon is a long-time resident of Carbondale and has been active at SIU School of Medicine since its inception. Dr. Ezdinli lives in Kenilworth and is a very active member of the faculty of the Chicago Medical School.

Family Practice is represented by James G. Ekeberg, M.D. of Palatine and Carl Neuhoff, M.D. who practices in Peoria. Dr. Ekeberg is in full-time private practice and Dr. Neuhoff holds a clinical appointment at the University of Illinois Peoria School of Medicine.

Raymond A. Dieter, Jr., M.D. represents General Surgery. He practices in Glen Ellyn, was president of the Du Page County Medical Society in 1977, and is a clinical assistant professor of surgery at Loyola/Stritch School of Medicine. Pediatrics is ably represented by Daniel R. Cunningham, M.D. of Wilmette, a faculty member at Northwestern University School of Medicine.

Constantine S. Soter, M.D., a Radiologist practicing in Arlington Heights, brings expertise in that field. Pathology and Obstetrics and Gynecology are represented by Donald D. Van Fossan and myself respectively, both of Springfield, and both associated with Southern Illinois University School of Medicine.

We will need the help of many others in this task. When material outside our areas of expertise require review, we shall call on many of you. We shall also call on you from time to time for your input in matters of form and content. Hopefully, we shall all work together and be able to carry on in the tradition of Dr. VanDellen to make the Illinois Medical Journal an even better publication.

# *Clinical experience & continuing confidence*

KAON® ELIXIR was introduced in **1954,** followed by KAON® TABLETS in **1963.** Decades of clinical experience indicate acceptability, effectiveness, and safety in the majority of patients; should abdominal pain occur, therapy should be discontinued. Both have been taken by patient after patient, day after day, year after year, to correct potassium deficiencies. Both have consistently demonstrated their value when diet alone is inadequate for potassium replacement.

## Kaon® Elixir
(potassium gluconate)

## Kaon® Tabs
(potassium gluconate)

BRIEF SUMMARY
**Kaon Tablets/Kaon Elixir**

**KAON® (potassium gluconate) TABLETS**

**Description:** Each sugar-coated tablet supplies 5 mEq. of elemental potassium (as potassium gluconate 1.17 Gm.). Kaon Tablets are sugar coated, not enteric coated, which favors dissolution in the stomach and absorption before reaching the small intestine where the lesions with enteric potassium chloride have occurred. The sugar coating merely adds to palatability and ease of swallowing, not to delay absorption as does the enteric coating.
**Indications:** Oral potassium therapy for the prevention and treatment of hypokalemia which may occur secondary to diuretic or corticosteroid administration. It may be used in the treatment of cardiac arrhythmias due to digitalis intoxication.
**Contraindications:** Severe renal impairment with oliguria or azotemia, untreated Addison's disease, adynamia episodica hereditaria, acute dehydration, heat cramps and hyperkalemia from any cause.
**Warning:** There have been several reports, published and unpublished, concerning nonspecific small-bowel lesions consisting of stenosis, with or without ulceration, associated with the administration of enteric-coated potassium tablets alone or when they are used with nonenteric-coated thiazides or certain other oral diuretics. These small-bowel lesions have caused obstruction, hemorrhage and perforation. Surgery was frequently required and deaths have occurred. Available information tends to implicate enteric-coated potassium salts, although lesions of this type also occur spontaneously Therefore, coated potassium-containing formulations should be administered only when indicated and should be discontinued immediately abdominal pain, distention, nausea, vomiting, or gastrointestinal bleeding occur. Coated potassium tablets should be used only when adequate dietary supplementation is not practical.
**Precautions:** In response to a rise in the concentration of body potassium, renal excretion of ion is increased. With normal kidney function it is difficult, therefore, to produce potassium intoxication by oral administration. However, potassium supplements must be administered with caution, since the amount of the deficiency or daily dosage is not accurately known. Frequent checks of the clinical status of the patient and periodic ECG and/or serum potassium levels should be made. High serum concentra-

*Time is the test of all things*



1954
1978

ıs of potassium ion may cause death through diac depression, arrhythmias or arrest. This g should be used with caution in the presence cardiac disease.

n hypokalemic states, especially in patients a salt-free diet, hypochloremic alkalosis is a sibility that may require chloride as well as assium supplementation. In these circum- nces, Kaon (potassium gluconate) should be plemented with chloride. Ammonium chlo- e is an excellent source of chloride ion (18.7 q. per Gram), but it should not be used in ients with hepatic cirrhosis where ammonium ts are contraindicated. Other sources for oride are sodium chloride and Diluted drochloric Acid, U.S.P.

t should also be kept in mind that ammonium le cation exchange resin, sometimes used to at hyperkalemia, should not be administered to patients with hepatic cirrhosis.

**Adverse Reactions:** Nausea, vomiting, diarrhea and abdominal discomfort have been reported. The symptoms and signs of potassium intoxication include paresthesias of the extremities, flaccid paralysis, listlessness, mental confusion, weakness and heaviness of the legs, fall in blood pressure, cardiac arrhythmias and heart block. Hyperkalemia may exhibit the following electrocardiographic abnormalities: disappearance of the P wave, widening and slurring of QRS complex, changes of the S-T segment, tall peaked T waves, etc.

**Overdosage:** Potassium intoxication may result from overdosage of potassium or from therapeutic dosage in conditions stated under "Contraindications." Hyperkalemia, when detected, must be treated immediately because lethal levels can be reached in a few hours.

**KAON® (potassium gluconate) ELIXIR**

**Description:** Each 15 ml. (tablespoonful) supplies 20 mEq. of elemental potassium (as potassium gluconate, 4.68 Gm.) with saccharin and aromatics. Alcohol 5%.

**Indications:** See Kaon Tablets.

**Precautions:** See Kaon Tablets.

In hypochloremic alkalosis, potassium replacement with potassium chloride (e.g., Kaochlor® 10% Liquid) may be more advantageous than with other potassium salts.

**Adverse Reactions:** See Kaon Tablets.

**Overdosage:** See Kaon Tablets.

**WARREN-TEED**
LABORATORIES, INC.
DIVISION OF **ADRIA LABORATORIES INC.**
COLUMBUS, OHIO 43215

# A New Vision of Catapres® (clonidine HCl)

# 20/20

## The first 20 days

- Catapres lowers blood pressure promptly.
- No contraindications.
- Some patients may have dry mouth, drowsiness, and sedation. Tell them that these tend to diminish with continued use.
- Giving the larger part of the divided dose at bedtime can help alleviate drowsiness and sedation

## The next 20 years*

- Lowered blood pressure.
- Little impotence, depression or postural hypotension.
- No fatal hepatotoxicity in over a decade of worldwide use.
- Broad therapeutic dosage range to keep step with changing dosage needs over the years

*Tolerance may develop in some patients, necessitating a reevaluation of therapy.

For full details on adverse reactions, warnings, and precautions, see brief summary of the prescribing information on last page of this advertisement





**Catapres®** (clonidine HCl)
**For Step 2 in Hypertension**

HYPERTENSION

# A New Vision of Catapres®

## (clonidine HCl)

Tablets of 0.1 and 0.2 mg




## What you do the first 20 days Can help him the next 20 years

**Catapres®**
**(clonidine hydrochloride)**
Tablets of 0.1 mg and 0.2 mg

**Indication:** The drug is indicated in the treatmer hypertension. As an antihypertensive drug, Cata (clonidine hydrochloride) is mild to moderate in It may be employed in a general treatment progr with a diuretic and/or other antihypertensive age as needed for proper patient response.

**Warnings:** Tolerance may develop in some patie necessitating a reevaluation of therapy.
*Usage in Pregnancy:* In view of embryotoxic find animals, and since information on possible adve effects in pregnant women is limited to uncontr clinical data, the drug is not recommended in w who are or may become pregnant unless the pot benefits outweigh the potential risk to mother a
*Usage in Children:* No clinical experience is ava with the use of Catapres (clonidine hydrochlorid children.

**Precautions:** When discontinuing Catapres (clo hydrochloride), reduce the dose gradually over 2 4 days to avoid a possible rapid rise in blood pr and associated subjective symptoms such as ne ness, agitation, and headache. Patients should instructed not to discontinue therapy without co their physician. Rare instances of hypertensive lopathy and death have been recorded after ces of clonidine hydrochloride therapy. A causal rel ship has not been established in these cases. I been demonstrated that an excessive rise in blo sure, should it occur, can be reversed by resum of clonidine hydrochloride therapy or by intrave nous phentolamine. Patients who engage in pot tially hazardous activities, such as operating m or driving, should be advised of the sedative ef This drug may enhance the CNS-depressive eff alcohol, barbiturates and other sedatives. Like agent lowering blood pressure, clonidine hydro should be used with caution in patients with se coronary insufficiency, recent myocardial infarc cerebrovascular disease or chronic renal failure

As an integral part of their overall long-term patients treated with Catapres (clonidine hydrc should receive periodic eye examinations. Whil except for some dryness of the eyes, no drug-r abnormal ophthalmologic findings have been r with Catapres (clonidine hydrochloride), in sev studies the drug produced a dose-dependent i in the incidence and severity of spontaneously ring retinal degeneration in albino rats treated 6 months or longer.

**Adverse Reactions:** The most common reactio dry mouth, drowsiness and sedation. Constipa dizziness, headache, and fatigue have been re Generally these effects tend to diminish with c therapy. The following reactions have been ass with the drug, some of them rarely. (In some ir an exact causal relationship has not been esta These include: Anorexia, malaise, nausea, vom parotid pain, mild transient abnormalities in li tion tests; one report of possible drug-induce titis without icterus and hyperbilirubinemia in receiving clonidine hydrochloride, chlorthalid papaverine hydrochloride. Weight gain, transi tion of blood glucose, or serum creatine phos congestive heart failure, Raynaud's phenomer dreams or nightmares, insomnia, other behavi changes, nervousness, restlessness, anxiety a depression. Also rash, angioneurotic edema, h urticaria, thinning of the hair, pruritus not ass with a rash, impotence, urinary retention, incr sensitivity to alcohol, dryness, itching or burn eyes, dryness of the nasal mucosa, pallor, gyr mastia, weakly positive Coombs' test, asympt electrocardiographic abnormalities manifeste Wenckebach period or ventricular trigeminy.

**Overdosage**: Profound hypotension, weaknes lence, diminished or absent reflexes and vom lowed the accidental ingestion of Catapres (c hydrochloride) by several children from 19 mo 5 years of age. Gastric lavage and administra analeptic and vasopressor led to complete rec within 24 hours. Tolazoline in intravenous dos 10 mg at 30-minute intervals usually abolishe fects of Catapres (clonidine hydrochloride) ov

**How Supplied:** Catapres, brand of clonidine h chloride, is available as 0.1 mg (tan) and 0.2 (orange) oval, single-scored tablets in bottles and 1000.

For complete details, please see full presc information.

Under license from Boehringer Ingelheim (

Boehringer Ingelheim Ltd
Ridgefield, CT. 06877

# *Obituaries*

*Anderson, Perry A., Rockford, died March 1 at the age of 69. Doctor Anderson was a 1933 graduate of Northwestern Medical School.

Bauer, Otto F., Granite City, died February 23 at the age of 61. Doctor Bauer was a 1941 graduate of the University of Bonn, Bonn, Germany.

Cheronis, Chris J., Chicago, died January 8 at the age of 68.

Clements, Albert D., Harvey, died June 10, 1977.

**Cooper, Hugh Edwin, Peoria, died March 16 at the age of 89. Doctor Cooper was a 1913 graduate of Rush Medical College.

*Guerrero, Severo R., Chicago, died March 14 at the age of 81. Doctor Guerrero was a 1930 graduate of the Loyola University Stritch School of Medicine.

*Holinger, Paul H., Chicago, died March 26 at the age of 72. Doctor Holinger was a 1933 graduate of Northwestern Medical School.

Ivy, Andrew C., Oak Park, died February 7 at the age of 84.

James, Joseph L., Chicago, died March 1 at the age of 92.

LaMarre, Victor N., Chicago, died February 21 at the age of 95.

Larson, John David, Hinsdale, died in December of 1977.

**Leonard, Charles Luke, Rockford, died March 6 at the age of 74. Doctor Leonard was a 1927 graduate of the Loyola University Stritch School of Medicine.

*May, Percy C., Centralia, died March 28 at the age of 72. Doctor May was a 1933 graduate of Howard University Medical School.

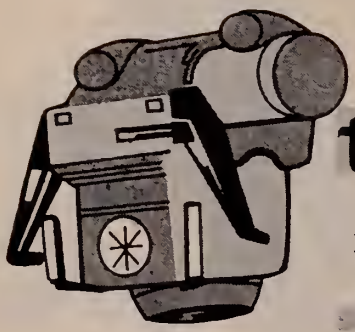
**Modert, Alison W., Mt. Vernon, died February 8 at the age of 87. Doctor Modert was a 1916 graduate of the Loyola University Stritch School of Medicine.

**O'Britis, Constance A., Webb Lake, Wisconsin, formerly of Chicago, died March 19 at the age of 82. Doctor O'Britis was a 1918 graduate of Temple University Medical School.

*Pobanz, Donovan M., Chicago, died March 16 at the age of 55. Doctor Pobanz was a 1949 graduate of Indiana University Medical School.

*Indicates ISMS member.*
***Indicates member of the ISMS Fifty Year Club.*

Modane® (danthron) LAXATIVE TABLETS
one tablet usually brings gentle, overnight relief
WARREN-TEED LABORATORIES, INC.
DIVISION OF ADRIA LABORATORIES INC.
COLUMBUS, OHIO 43215

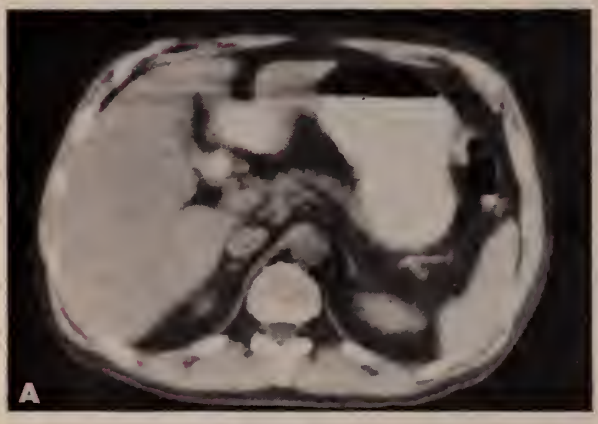


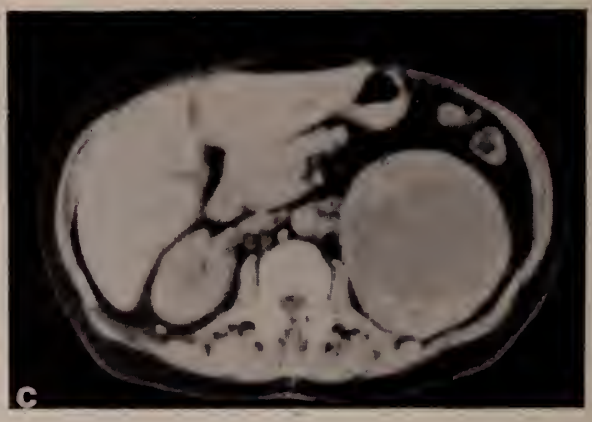
# the view box

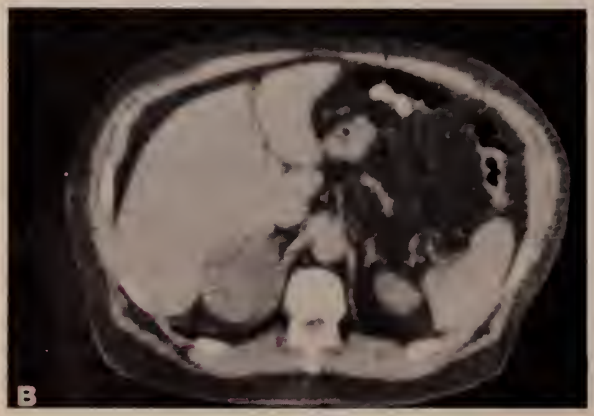
Leon Love, M.D./Chairman/Department of Radiology
Loyola University Stritch School of Medicine

## CT of Adrenal Glands

By Carl J. Reynes, M.D., Robert J. Churchill, M.D.,
and Leon Love, M.D./Maywood




### *What are your Diagnoses?*

| | |
|---|---|
| 1. Normal adrenal glands | A, B, or C |
| 2. Adrenal pseudocyst | A, B, or C |
| 3. Adrenal solid mass | A, B, or C |

*(Continued on page 404)*



**"I'm just a shadow of what I used to be."**

That is what depressed individuals may feel is the substance of their being. There is no pleasure, no joy – nothing grows – and in the cold shadow of depression their activities are inhibited, while initiative may be eroded or destroyed. The tragedy is that they can see that others are able to live on the brighter side but they, themselves, cannot reach it on their own.

Your experience in treating depression, and Tofranil-**PM** can help light the way.

# Tofranil-**PM**®
imipramine **pamoate**

Geigy

## Unsurpassed effectiveness among tricyclics in relieving symptoms of anxious depression.

Before prescribing Tofranil-PM, please review a summary of the prescribing information on the back of this page.

# Tofranil-PM®
imipramine **pamoate**

Geigy

As anxiety, agitation, sleep disturbances, and other depressive symptoms are relieved, mood and motivation may be markedly improved.

Patients are usually alert and capable of functioning at more normal levels of behavior.

Tofranil-PM encourages patient compliance because one capsule lasts from bedtime to bedtime.

Good results are usually seen at the starting dose of one 75-mg capsule h.s.

For many patients, dosage can be safely increased to 150 mg daily.

As with all tricyclics, sedation may occur. Please caution patients against driving or ope ating dangerous machinery.

Each capsule contains imipramine pamoate equivale to 75, 100, 125 or 150 mg of imipramine hydrochloride.

**Tofranil-PM®**
**brand of imipramine pamoate**

**Indications:** For the relief of symptoms of depression. Endogenous depression is more likely to be alleviated than other depressive states.

**Contraindications:** The concomitant use of monoamine oxidase inhibiting compounds is contraindicated. Hyperpyretic crises or severe convulsive seizures may occur in patients receiving such combinations. The potentiation of adverse effects can be serious, or even fatal. When it is desired to substitute Tofranil-PM, brand of imipramine pamoate, in patients receiving a monoamine oxidase inhibitor, as long an interval should elapse as the clinical situation will allow, with a minimum of 14 days. Initial dosage should be low and increases should be gradual and cautiously prescribed. The drug is contraindicated during the acute recovery period after a myocardial infarction. Patients with a known hypersensitivity to this compound should not be given the drug. The possibility of cross-sensitivity to other dibenzazepine compounds should be kept in mind.

**Warnings:** *Usage in Pregnancy:* Safe use of imipramine during pregnancy and lactation has not been established; therefore, in administering the drug to pregnant patients, nursing mothers, or women of childbearing potential, the potential benefits must be weighed against the possible hazards. Animal reproduction studies have yielded inconclusive results. There have been clinical reports of congenital malformation associated with the use of this drug, but a causal relationship has not been confirmed.

Extreme caution should be used when this drug is given to:

—patients with cardiovascular disease because of the possibility of conduction defects, arrhythmias, myocardial infarction, strokes and tachycardia;
—patients with increased intraocular pressure, history of urinary retention, or history of narrow-angle glaucoma because of the drug's anticholinergic properties;
—hyperthyroid patients or those on thyroid medication because of the possibility of cardiovascular toxicity;
—patients with a history of seizure disorder because this drug has been shown to lower the seizure threshold;
—patients receiving guanethidine or similar agents since imipramine may block the pharmacologic effects of these drugs.

Since imipramine may impair the mental and/or physical abilities required for the performance of potentially hazardous tasks such as operating an automobile or machinery, the patient should be cautioned accordingly.

*Usage in Children:* Tofranil-PM, brand of imipramine pamoate, should not be used in children of any age because of the increased potential for acute overdosage due to the high unit potency (75 mg., 100 mg., 125 mg. and 150 mg.). Each capsule contains imipramine pamoate equivalent to 75 mg., 100 mg., 125 mg. or 150 mg. imipramine hydrochloride.

**Precautions:** It should be kept in mind that the possibility of suicide in seriously depressed patients is inherent in the illness and may persist until significant remission occurs. Such patients should be carefully supervised during the early phase of treatment with Tofranil-PM, brand of imipramine pamoate, and may require hospitalization. Prescriptions should be written for the smallest amount feasible.

Hypomanic or manic episodes may occur, particularly in patients with cyclic disorders. Such reactions may necessitate discontinuation of the drug. If needed, Tofranil-PM, brand of imipramine pamoate, may be resumed in lower dosage when these episodes are relieved. Administration of a tranquilizer may be useful in controlling such episodes.

Prior to elective surgery, imipramine should be discontinued for as long as the clinical situation will allow.

An activation of the psychosis may occasionally be observed in schizophrenic patients and may require reduction of dosage and the addition of a phenothiazine.

In occasional susceptible patients or in those receiving anticholinergic drugs (including antiparkinsonism agents) in addition, the atropine-like effects may become more pronounced (e.g., paralytic ileus). Close supervision and careful adjustment of dosage is required when this drug is administered concomitantly with anticholinergic or sympathomimetic drugs.

Avoid the use of preparations, such as decongestants and local anesthetics, which contain any sympathomimetic amine (e.g., adrenalin, noradrenalin), since it has been reported that tricyclic antidepressants can potentiate the effects of catecholamines.

Patients should be warned that the concomitant use of alcoholic beverages may be associated with exaggerated effects.

Both elevation and lowering of blood sugar levels have been reported.

Concurrent administration of imipramine with electroshock therapy may increase the hazards; such treatment should be limited to those patients for whom it is essential, since there is limited clinical experience.

**Adverse Reactions:** Note: Although the listing which follows includes a few adverse reactions which have not been reported with this specific drug, the pharmacological similarities among the tricyclic antidepressant drugs require that each of the reactions be considered when imipramine is administered.

*Cardiovascular:* Hypotension, hypertension, tachycardia, palpitation, myocardial infarction, arrhythmias, heart block, stroke, falls.

*Psychiatric:* Confusional states (especially in the elderly) with hallucinations, disorientation, delusions; anxiety, restlessness, agitation; insomnia and nightmares; hypomania; exacerbation of psychosis.

*Neurological:* Numbness, tingling, paresthesias of extremities; incoordination, ataxia, tremors; peripheral neuropathy; extrapyramidal symptoms; seizures, alterations in EEG patterns; tinnitus.

*Anticholinergic:* Dry mouth, and, rarely, associated sublingual adenitis; blurred vision, disturbances of accommodation, mydriasis; constipation, paralytic ileus; urinary retention, delayed micturition, dilation of the urinary tract.

*Allergic:* Skin rash, petechiae, urticaria, itching, photosensitization (avoid excessive exposure to sunlight); edem (general or of face and tongue); drug fever; cross-sensitivity with desipramine.

*Hematologic:* Bone marrow depression including agran ulocytosis; eosinophilia; purpura; thrombocytopenia. Leukocyte and differential counts should be performed any patient who develops fever and sore throat during therapy; the drug should be discontinued if there is evi dence of pathological neutrophil depression.

*Gastrointestinal:* Nausea and vomiting, anorexia, epiga tric distress, diarrhea; peculiar taste, stomatitis, abdom cramps, black tongue.

*Endocrine:* Gynecomastia in the male; breast enlargement and galactorrhea in the female; increased or decreased libido, impotence; testicular swelling; elevatio depression of blood sugar levels.

*Other:* Jaundice (simulating obstructive); altered liver function; weight gain or loss; perspiration; flushing; uri nary frequency; drowsiness, dizziness, weakness and fatigue; headache; parotid swelling; alopecia.

*Withdrawal Symptoms:* Though not indicative of addict abrupt cessation of treatment after prolonged therapy may produce nausea, headache and malaise.

**Dosage and Administration:** In adult outpatients, therapy should be initiated on a once-a-day basis with mg./day. This may be increased to 150 mg./day which the dose level which usually obtains optimum respons necessary, dosage may be increased to 200 mg./day. Dosage should be modified as necessary by clinical re sponse and any evidence of intolerance. Daily dosage may be given at bedtime, or in some patients in divide daily doses.

Hospitalized patients should be started on a once-a-da basis with 100-150 mg./day and may be increased to mg./day. Dosage should be increased to 250-300 mg. if there is no response after two weeks.

Following remission, maintenance medication may be quired for a longer period of time at the lowest dose th will maintain remission. The usual adult maintenance dosage is 75-150 mg./day on a once-a-day basis, prel ably at bedtime.

In adolescent and geriatric patients, capsules of Tofra PM, brand of imipramine pamoate, may be used wher total daily dosage is established at 75 mg. or higher. It generally unnecessary to exceed 100 mg./day in thes patients. This dosage may be given once a day at bec time or, if needed, in divided daily doses.

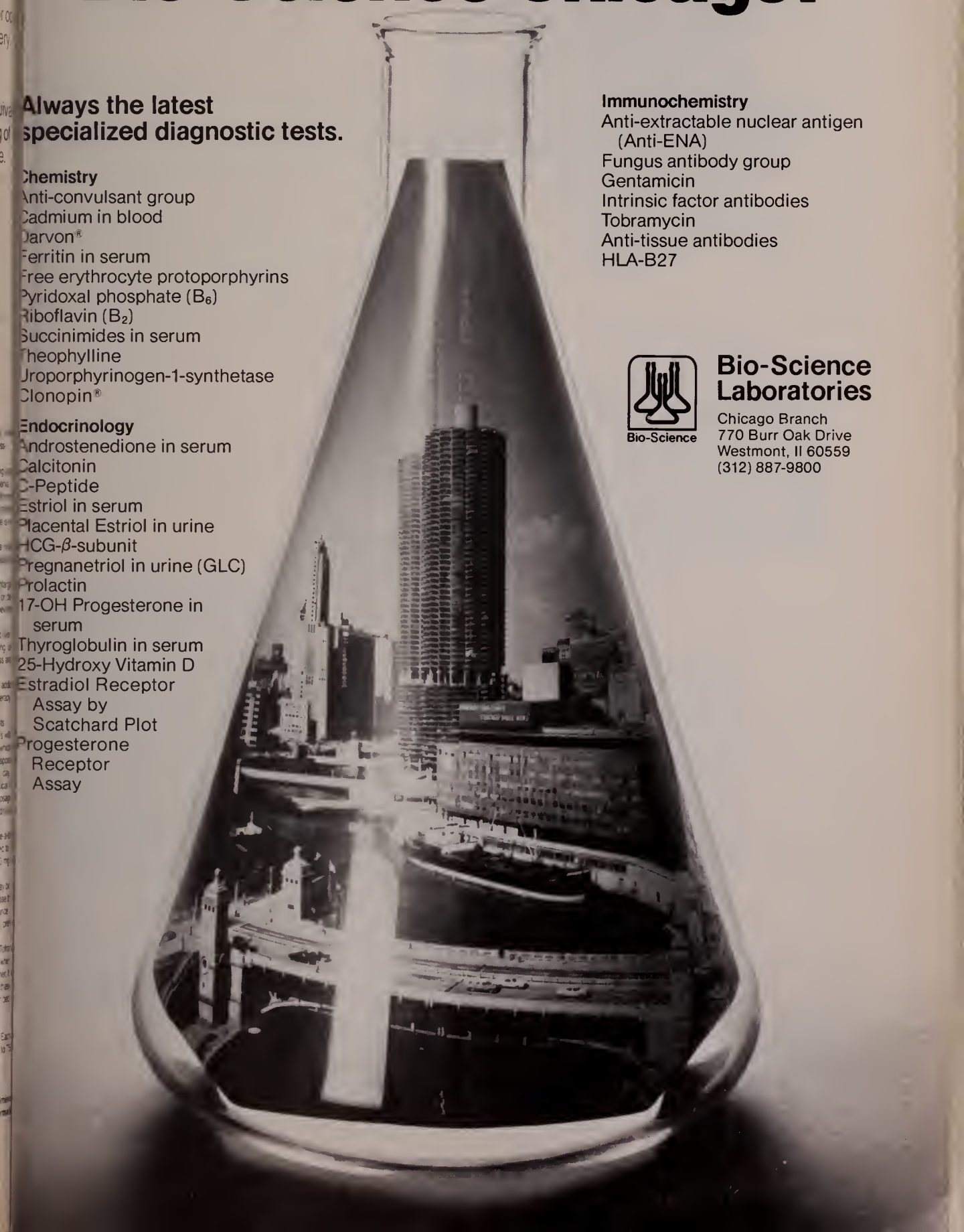
**How Supplied:** Tofranil-PM, brand of imipramine pamoate: Capsules of 75, 100, 125 and 150 mg. (Eac capsule contains imipramine pamoate equivalent to 7 100, 125 or 150 mg. of imipramine hydrochloride.)
(B) 98-146-840-A(9/75) 667120

**For complete details, including dosage and admin tration, please refer to the full prescribing informa**

GEIGY Pharmaceuticals
Division of CIBA-GEIGY Corporation
Ardsley, New York 10502

Printed in U.S.A. (10-77) TO 12889

# What's new at Bio-Science Chicago?



## Always the latest specialized diagnostic tests.

**Chemistry**
Anti-convulsant group
Cadmium in blood
Darvon®
Ferritin in serum
Free erythrocyte protoporphyrins
Pyridoxal phosphate ($B_6$)
Riboflavin ($B_2$)
Succinimides in serum
Theophylline
Uroporphyrinogen-1-synthetase
Clonopin®

**Endocrinology**
Androstenedione in serum
Calcitonin
C-Peptide
Estriol in serum
Placental Estriol in urine
HCG-$\beta$-subunit
Pregnanetriol in urine (GLC)
Prolactin
17-OH Progesterone in serum
Thyroglobulin in serum
25-Hydroxy Vitamin D
Estradiol Receptor Assay by Scatchard Plot
Progesterone Receptor Assay

**Immunochemistry**
Anti-extractable nuclear antigen (Anti-ENA)
Fungus antibody group
Gentamicin
Intrinsic factor antibodies
Tobramycin
Anti-tissue antibodies
HLA-B27

Bio-Science

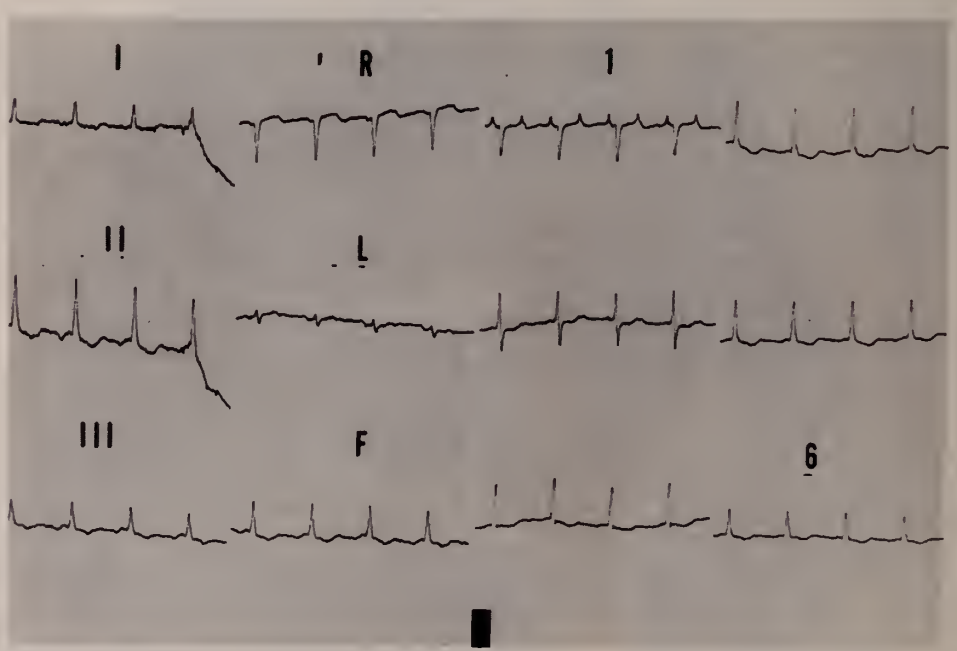
**Bio-Science Laboratories**

Chicago Branch
770 Burr Oak Drive
Westmont, Il 60559
(312) 887-9800

# ekg of the month

John F. Moran, M.S., M.D., David L. Fishman, M.D.,
Patrick J. Scanlon, M.D., Sarah A. Johnson, M.D.,
John R. Tobin, M.S., M.D., and Rolf M. Gunnar, M.S., M.D.
Section of Cardiology, Department of Medicine,
Loyola University Stritch School of Medicine

This forty-nine-year-old lady presented with a long history of gradually worsening dyspnea. Over several months, she had developed orthopnea, paroxysmal nocturnal dyspnea, and edema. She also claimed her abdomen was swelling. This was difficult to assess because she weighed over 300 pounds. Her physical exam showed a grossly obese woman who was breathless at rest. Her blood pressure was normal. A paradoxical blood pressure response could not be easily determined because of the arm size. Her neck veins were distended and the pulmonary exam showed crepitant rales to mid-scapula bilaterally. Heart sounds were distant but seemed normal. The abdomen was large due to obesity and ascites. Her legs showed 4+ pitting edema to the knees. A chest X-ray showed a normal-sized heart with pericardial calcifications, subsequently confirmed by X-ray tomography. The lung fields on X-ray were compatible with congestive heart failure. She was treated with digitalis and diuretics and lost fifteen pounds but did not feel better. This ECG was taken.



## Questions:

1. **The ECG shows:**
   - A. Atrial flutter with 2:1 atrioventricular (AV) block.
   - B. Left ventricular hypertrophy.
   - C. Atrial tachycardia with 2:1 AV block.
   - D. ST-T wave changes compatible with digitalis effect.
   - E. Marked left axis deviation.

2. **The following statement(s) are true:**
   - A. The hallmark of this disease on physical examination is the persistence of jugular venous distension after adequate diuresis.
   - B. The cardiac silhouette on chest X-ray may often be normal.
   - C. Low QRS voltage is frequently seen on the ECG.
   - D. This patient requires cardiac catheterization possibly with volume loading to evaluate the cardiac pressures.
   - E. All of the above.

*(Continued on page 407)*


LEASE NOW

**PORSCHE 911**
The ultimate sports machine. We have the largest inventory in the midwest.



**AUDI 5000**
The sensible luxury car. All types of leases available, long or short term.



**NOW RESERVING LEASE DATES FOR PORSCHE 928's!**

Doctors have special transportation needs and we have been filling them with incomparable automobiles for years. Leasing your next car makes good economic sense and we'd like to show you why.

O'HARE
INTERNATIONAL AUTOS
The Midwest's Largest Porsche, Audi and Mazda Dealer
CALL VINCE PISHA (312) 297-2880

LOW-COST GROUP INSURANCE ANOTHER ISMS MEMBERSHIP PRIVILEGE

**THE GROUP DISABILITY PLAN** ● Provides up to $1,732.00 monthly in the event of disability caused by Accident or Sickness. ● Special Guaranteed renewal feature. ● Protect your income and security.

**BUSINESS OVERHEAD EXPENSE PLAN** ● Pays your office overhead expense when disability strikes. ● Premiums are Tax Deductible. ● Pays in Addition to the Disability Plan Benefits.

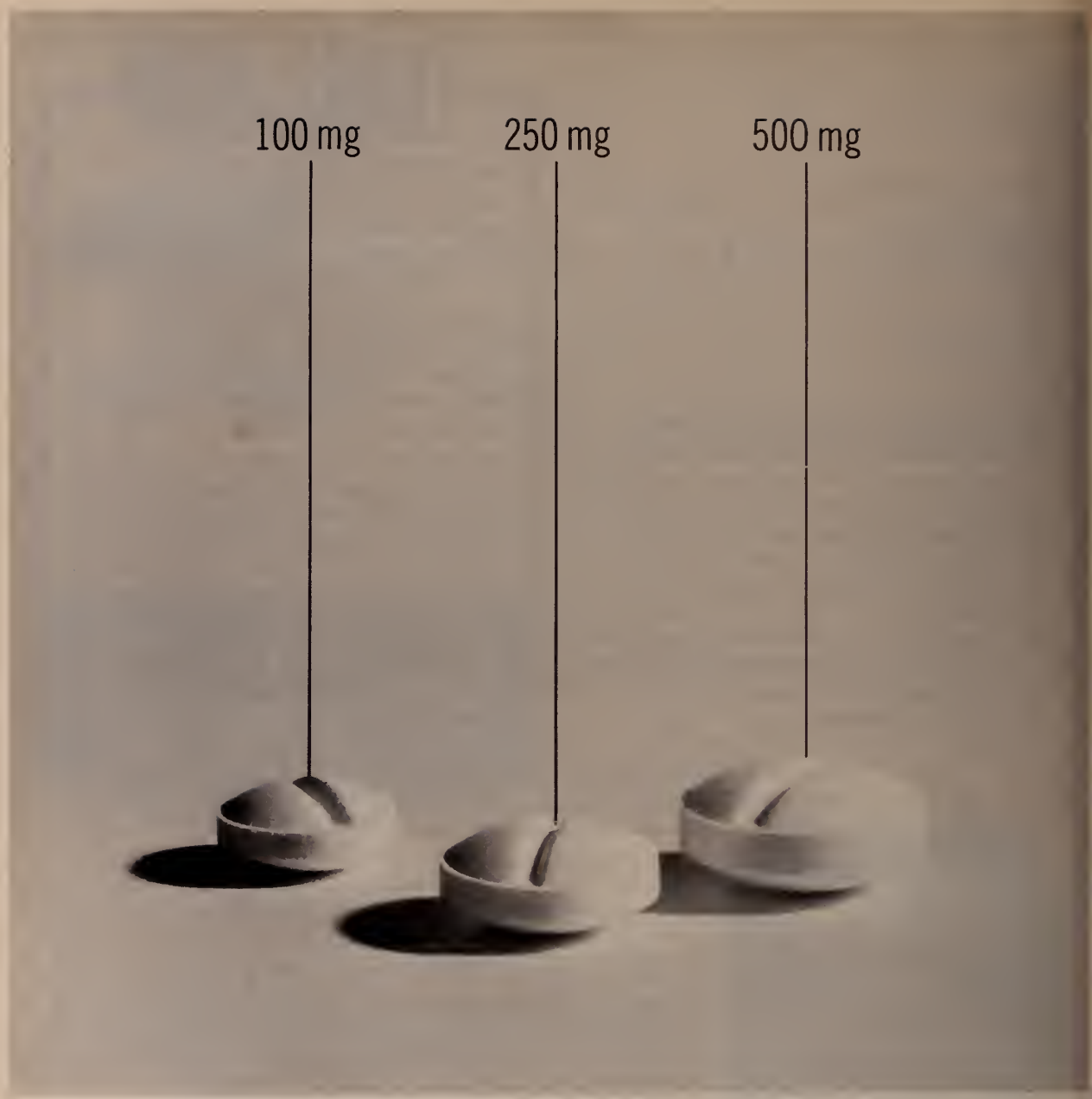
**THE BASIC MAJOR MEDICAL EXPENSE PLAN** ● In or out of Hospital Benefits up to $25,000.00 per Disability. ● Up to $100.00 Daily Hospital Room and Board maximum. ● Subject to choice of deductible and 80% coinsurance.

**EXCESS MAJOR MEDICAL PLAN** ● Provides up to $250,000 for Medical Expenses. ● Supplements **any** Basic Major Medical Plan and has a $25,000 deductible. ● Low group rates. ● Truly **catastrophic coverage.**

FOR INFORMATION, ASSISTANCE & DETAILS CONTACT:

Administrators:
PARKER, ALESHIRE & COMPANY
ESTABLISHED 1901
Insurance

9933 N. Lawler Avenue
Skokie, Illinois 60076
Phone: 312-679-1000




# Tolinase®
## tolazamide, Upjohn

Please contact your Upjohn representative for additional product information.

Upjohn

J-5695-6

©1977 THE UPJOHN COMPANY

IMJ
Illinois Medical Journal
Vol. 153, No. 5, May, 1978

# Impact of Community Mental Health Programs on Hospitalization for Mental Illness

## An Historical Perspective

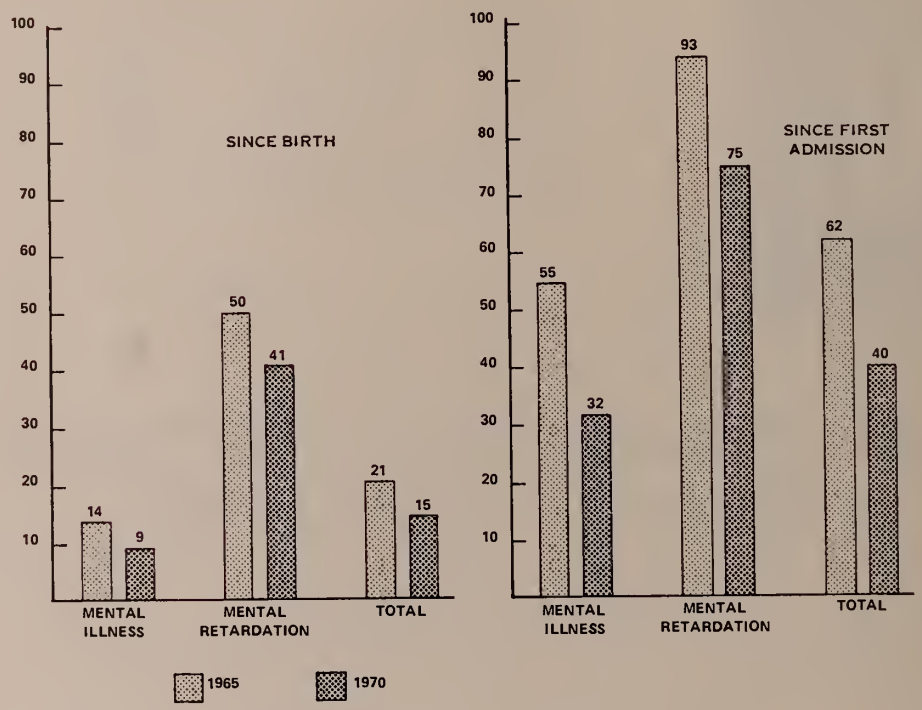
By William G. Smith, M.D., Margaret Krzyzanowski, B.A. and Randall Heinemann, M.A.P.A./Rockford

*This study reports the mental hospital experience of an entire population in a region typical of midwest America before and after the introduction of the community mental health orientation and a major increase in treatment resources. The overall prevalence of mental hospitalization remained at a steady rate between 1965 and 1970. First admissions dropped sharply as did average time hospitalized in all diagnostic groupings. A portion of discharged patients did not actually improve but were cared for in community residential facilities and a small minority remained too disturbed for discharge to the community. Thus, while the community approach lessened disability due to hospitalization, it did not affect cure of the most seriously disordered persons and long term support of these patients still remains a significant challenge and a drain upon societal resources.*

One of the principal goals of the community mental health movement is to decrease long-term hospitalization due to mental illness. Long-term confinement is one marker of disability—a person cannot be a full, productive member of a community while hospitalized. In addition, some observers believe that long-term institutional care actually aggravates disability by causing individuals to lose social skills necessary for survival in a community. As a first attempt to assess the question of mental disability, this study focused on the impact of the community mental health approach vis-a-vis the hospitalization experience of an entire regional population. It corroborates and extends the findings of similar statistical investigations and offers several caveats on interpretation of such data.[1,2]

Between 1965 and 1970, a community oriented approach to mental health and a substantial increase in services became available to the 600,000 citizens of ten counties in northern Illinois. This region is typical demographically and culturally (medium sized industrial cities and intensive farming) of the midwest United States (outside major metropolitan areas). In 1965, the region was served by four psychiatrists and one county mental health clinic. Most services for seriously disturbed persons were provided

TABLE 1 MEAN PERCENT TIME HOSPITALIZED PER PATIENT TIME AT RISK FOR PATIENTS HOSPITALIZED DURING 1965 & 1970




by three distant State hospitals. By 1970, there were 18 psychiatrists, a 30-bed general hospital psychiatric unit, a new State regional mental health center, four additional community mental health clinics and over 40 agencies serving the mentally ill and mentally retarded in the area. Expenditures in the public sector rose from $8.00 per capita to $38.00. Using the Consumer Price Index to adjust for inflation, these figures were $8.48 and $32.68, respectively.

## Methodology

All residents of the ten counties who were hospitalized for mental illness at any time during 1965 (a full year prior to the inauguration of the regional program) were compared with patients hospitalized during 1970 (after the program had become well established). Both cohorts included last day census and admissions during these two years.

All persons with home addresses within the ten counties who were hospitalized at any time during the sample years for mental illness or retardation were identified. These identification surveys covered all Department of Mental Health and Developmental Disabilities facilities within Illinois, all Veterans' Administration hospitals, private psychiatric hospitals, psychiatric units in general hospitals, and residential treatment facilities within the ten counties and within a 50-mile radius of the region including the Chicago metropolitan area. From these lists a 10% random sample stratified by type of facility was drawn, yielding a sample of 585 patients for 1965 and 610 for 1970.

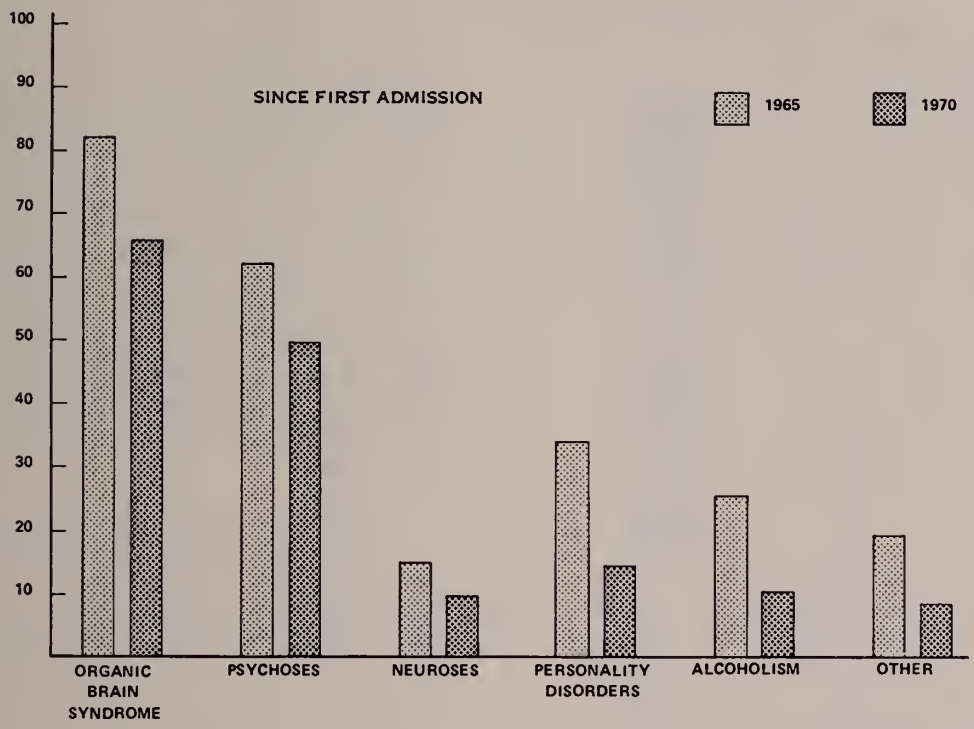
Data was abstracted from the medical records according to a standardized protocol (available upon request). The data were of two types: (1) demographic data and (2) all information describing admissions and lengths of stay during the sample years and at any time prior to the sample years. Because the study focused on long-term hospitalization, three parameters were defined and examined for members of the sample cohorts: (1) days hospitalized since birth in any psychiatric facility, (2) days hospitalized since first admission and (3) days hospitalized during the cohort years.

## Results

*Demographic Data*

The annual prevalence rate for hospitaliza-

TABLE 2 MEAN PERCENT OF TIME HOSPITALIZED PER PATIENT TIME AT RISK FOR PATIENTS HOSPITALIZED DURING 1965 AND 1970 BY DIAGNOSTIC CATEGORY




tion remained constant from 1965 to 1970. Approximately 1% of the area's population was hospitalized for some mental disturbance during each year; public facilities (State-run and V.A.) served 80% of the hospitalized persons and 20% were served by private psychiatric facilities. Median age of the general population remained approximately 28, while median age of the hospitalized population declined from 47 to 42. There were no changes in the proportion of males and females nor in the socioeconomic status distribution of the samples.

*Admission and Length-of-Stay Data*

While the absolute number of psychiatric patients served increased slightly between 1965 and 1970 (paralleling population growth), the average length of stay decreased. During 1965, the patient cohort spent approximately three hospitalized days per 1000 days lived during that year; the 1970 figure was two days. Mean length of stay during the study years for the mentally ill decreased from 6 to 3.5 months. The length of stay for the mentally retarded decreased from eleven months to nine.

Table 1 compares total time hospitalized. It can be seen that those who were hospitalized in 1970 had spent a smaller portion of their lives since birth and since their first admission in hospitals.

Table 2 shows the ratio of time spent hospitalized since first admission broken down by diagnostic categories. The 1970 patient cohort had spent less time hospitalized in each diagnostic category. As might be expected, those diagnosed as organically impaired or psychotic spent a larger portion of days at risk in hospitals. The greatest decreases were evident in the less severe diagnostic categories.

Comparing hospitalized days standardized over the entire population of the ten-county region, it can be seen in Table 3 that both the mentally ill and mentally retarded diagnostic categories showed decreases.

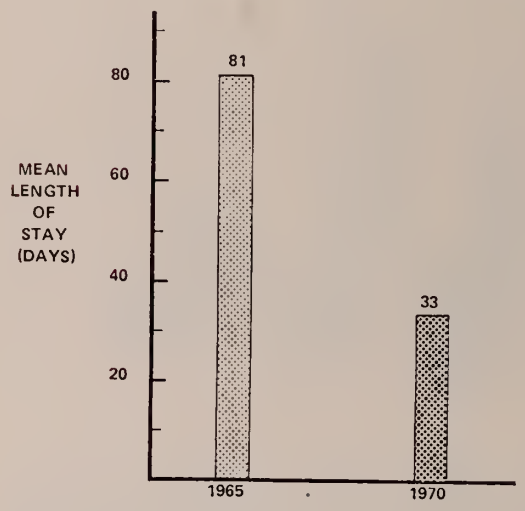
To get a truer picture of the degree to which the community mental health approach affected hospital stays, the patients who were admitted for the first time in each of the sample years were examined. As Table 4 shows, there was a 41% decrease in length of stay for the first admission groups between the two sample years.

Of those judged to be chronically disabled

TABLE 3 DAYS HOSPITALIZED PER CAPITA BY GROSS DIAGNOSTIC CATEGORY

| | Mentally Ill | | Mentally Retarded | | Total | |
|---|---|---|---|---|---|---|
| | 1965 | 1970 | 1965 | 1970 | 1965 | 1970 |
| Lifatima Days Hospitalized Par Capita | 11.6 | 7.2 | 6.6 | 5.3 | 18.2 | 12.5 |
| Days Hospitalized In Sampla Yaar Par Capita | 0.8 | 0.4 | 0.4 | 0.3 | 1.1 | 0.7 |

TABLE 4 MEAN LENGTH OF STAY FOR THOSE ADMITTED FOR THE FIRST TIME IN EACH OF THE SAMPLE YEARS




(spending 15% or more of their lifetime in hospitals), 22% were diagnosed as having organic brain syndrome while the remaining 78% were judged to be psychotic.

## Discussion and Conclusions

All of the length-of-stay data indicated that implementation of the community mental health concept was associated with a decrease in long-term hospitalization for the mentally ill and retarded. Average lengths of stay during 1970 dropped by nearly 60%, life-time lengths of hospitalization and time hospitalized since first admission also showed declines for all diagnostic categories. Standardized days hospitalized fell for the entire population. For many, these findings supported the contention that the community mental health approach lessened disability due to mental illness as reflected in long-term hospitalization.

It should be noted, however, that hospital utilization data cannot definitively establish that the community approach lessened disability. To establish a real decline in disability, it is necessary to further evaluate the social and psychological adjustment of discharged patients. While changes in hospital admissions and liberalized discharge policies are part of the community mental health orientation, they may merely represent administrative changes and conceal a considerable and real social disability. There is some evidence that this is the case. In one study conducted by the regional Center it was discovered that about 50% of those persons discharged after a year or more of hospital care required continued residential care in a structured setting, such as a nursing home or sheltered-care facility. Though these facilities are less restrictive than hospitals, their residents are still appreciably disabled with respect to symptoms and vocational adjustment.

Two other controlled follow-up studies carried out at the regional Center[1,4] indicated that the community approach was clearly successful with first admission patients (fewer days hospitalized, less vocational disability, and lower per-patient treatment costs), but not with patients who had previously accumulated significant histories of mental hospitalization. Of a total admission cohort, 12% required continuing residential care in a community facility and about 3% required long-term hospital care. Certainly the new approach did not cure serious mental disturbance, and adequate resources were still necessary for longer term care of the chronic minority.

In the seven years since these data were gathered, the trends reported here have continued although no precise figures are available. Inflation-adjusted total hospital costs have declined with shorter lengths of stay while community care costs have risen sharply. The small proportion of unresponsive patients still consume a disproportionate share of resources and have not been cured by the new community approach. Apparently, reorganization of the health delivery system and an optimistic treatment philosophy have made only a moderate dent in the overall morbidity associated with serious mental illness.

Of course, community services are not only directed toward patients at risk of hospitalization: they also serve less severely disturbed persons. Whether or not a decrease in long-term hospitalization and greater availability of service are worth the higher overall expenditure in pub-

lic funds can only be determined by what priority a society places upon the rehabilitation and care of its mentally disabled citizens. ◄


**References**

1. Kramer, Morton: "Issues in the Development of Statistical and Epidemiological Data for Mental Health Services Research," *Psychol. Med.*, Vol. 6, pp. 185-215, May, 1976
2. Sainsbury, Peter: "Evaluation of Community Mental Health Programs" in HANDBOOK OF EVALUATION RESEARCH, Vol. 2, pp. 125-159, M. Guttentag and E. Struening, *eds.*, *Sage*, 1975.



WILLIAM G. SMITH, M.D., is a professor of psychiatry at the University of Illinois Rockford School of Medicine. He is also a consultant far the H. Douglas Singer Zone Center, IDMHDD, where he formerly served as Superintendent and also IDMHDD Directar of Zane Mental Heolth Dato Services. Dactor Smith is o medical diplamate of the American Baard of Psychiatry ond Neurolagy.

MARGARET KRZYZANOWSKI is a reseorch analyst at the H. Dauglas Singer Mental Health Center in Rackford.

RANDALL HEINEMANN, M.A.P.A., is a research analyst at the H. Dauglas Singer Mental Heolth Center in Rockford and also Directar af Pragram Evaluatian and Development for the United Way of Rackford. He specializes in public administratian and program evoluation.



# STAFF PHYSICIAN



Expansion of services at Caterpillar Tractor Co., a multi-national corporation, has created exceptional opportunities at a new plant in Mossville, Illinois. Excellent salary; company paid life, health, and professional liability insurance; annual vacation; retirement program plus attractive stock purchase plan. An Equal Opportunity Employer. Send confidential resume to:

**P. B. Detweiler, M.D., Medical Director,**
**Basic Engine Plant,**
**CATERPILLAR TRACTOR CO.,**
**Mossville, Illinois 61552**

CATERPILLAR

## Professionals are talking about . . .




# CLOVER LEAF TOWERS OFFICE PLAZA

**Ideally located & suited for professionals.**

10 MINUTES TO I-90 • 30 MINUTES TO CHICAGO

**NEW 3 STORY • ALL ELECTRIC • WITH ELEVATOR**

- Heating & Air-Conditioning Included
- Carpeting — Your Color Choice
- More Than Ample Parking
- Fine Restaurant Located in Building
- Ideal For Medical, Dental Offices
- Entire Floor 10,000 Sq. Ft. — Will Divide
- Tinted Glass — FM Music
- Public & Private Restrooms
- 2 Year Lease — No Increase
- Solid Oak Doors — Vinyl Base
- Individually Controlled Thermostat
- Immediate Occupancy — Brokers Invited

## CLOVER-LEAF REALTY

**201 E. Army Trail (1½ Miles West of Rte. 53)**
**Bloomingdale, Ill.**
**PHONE 893-1000**



# new pharmaceutical specialties

By Paul Dehaen

For detailed information regarding indications, dosage, contraindications and adverse reactions, refer to the manufacturer's package insert or brochure.

**New Single Drugs**—Drugs not previously known, including new salts.

**Duplicate Single Drugs**—Drugs marketed by more than one manufacturer.

**Combination Products**—Drugs consisting of two or more active ingredients.

**New Dosage Forms**—Of a previously introduced product.

**The following new drugs have been marketed:**

## NEW SINGLE DRUGS

**LIORESAL** — Muscle Relaxant Rx

| | |
|---|---|
| Manufacturer: | Geigy Pharmaceuticals |
| Nonproprietary Name: | Baclofen |
| Indications: | Spasticity resulting from multiple sclerosis, some value in spinal cord injuries. |
| Warnings: | Not indicated in skeletal muscle spasm resulting from rheumatoid diseases. |
| Dosage: | Requires individual titration starting at a low dose |
| Supplied: | Tablets, 10 mg |

**NORPACE** — Antiarrhythmic Rx

| | |
|---|---|
| Manufacturer: | G. D. Searle & Co. |
| Nonproprietary Name: | Disopyramide |
| Indications: | Suppression and prevention of cardiac arrhythmias |
| Contraindication: | Cardiogenic shock. preexisting second or third degree AV block |
| Dosage: | Individualized: 400 to 800 mg per day in divided doses |
| Supplied: | Tablets 100 and 150 mg |

**STREPTASE** — Enzymes Rx

| | |
|---|---|
| Manufacturer: | Hoechst-Roussel Pharmaceuticals Inc. |
| Nonproprietary Name: | Streptokinase |
| Indications: | Pulmonary Embolism |
| Dosage: | See package insert |
| Supplied: | Lyophilized powder Vials, 6.5 ml 100,000, 250,000, 750,000 IU |

## DUPLICATE SINGLE DRUGS

**CANDEX** — Topical Fungicide Rx

| | |
|---|---|
| Manufacturer: | Dome Laboratories |
| Nonproprietary Name: | Nystatin |
| Indications: | Cutaneous or mucocutaneous mycotic infections caused by candida species. |
| Administration: | Apply two or three times daily Continue use for one week after clinical cure |
| Supplied: | Lotion, Plastic bottle 30 ml, 100,000 U/ml Cream, Tube, 15 mg, 100,000 U/g |

**SYMPTOM 1** — Cough Preparation o.t.c.

| | |
|---|---|
| Manufacturer: | Parke Davis |
| Nonproprietary Name: | Dextromethorphane |
| Indications: | Temporary relief of cough |
| Dosage: | 1 to 2 teaspoonful every 6 to 8 hours Children correspondingly reduced |
| Supplied: | Liquid, 5 ml/10 mg |

**SYMPTOM 2** — Nasal Decongestant o.t.c.

| | |
|---|---|
| Manufacturer: | Parke Davis |
| Nonproprietary Name: | Pseudoephedrine |
| Indications: | Temporary relief of nasal decongestion |
| Dosage: | 2 teaspoonfuls every 4 hours Children correspondingly reduced |
| Supplied: | Liquid, 5 ml/30 mg |

**SYMPTOM 3** — Cold Preparation-Antihistamine o.t.c.

| | |
|---|---|
| Manufacturer: | Parke Davis |
| Nonproprietary Name: | Brompheniramine maleate |
| Indications: | Temporary relief of running nose |
| Dosage: | 2 teaspoonfuls every 4 to 6 hours Children correspondingly reduced |
| Supplied: | Liquid, 5 ml/2 mg |

## COMBINATION PRODUCTS

**ABDEC Teens** — Vitamins o.t.c.

| | | |
|---|---|---|
| Manufacturer: | Parke-Davis | |
| Composition: | Vitamin A | 7,500 IU |
| | Vitamin D | 400 |
| | Vitamin E | 30 |
| | Vitamin C | 180 mg |
| | Vitamin $B_1$ | 4.5 mg |
| | Vitamin $B_2$ | 5.1 mg |
| | Vitamin $B_6$ | 6 mg |
| | Vitamin $B_{12}$ | 6 mcg |
| | Niacin | 60 mg |
| Indications: | Vitamin deficiencies in teenagers | |
| Supplied: | Tablets | |

# 1978 Convention Summary



*George T. Wilkins, Jr., M.D., (L) 1977-78 ISMS president, and David S. Fox, M.D., 1978-79 ISMS president. On Wednesday morning, April 5, 1978, Doctor Fox took the oath of office as the 126th president of the Illinois State Medical Society.*

## New Officers and Trustees . . .

## Highlights of Convention '78 . . .

## Summary of House Actions

# Illinois State Medical Society 1978-79 Officers and Board of Trustees

**Officers**

| | |
|---|---|
| PRESIDENT | David S. Fox, 826 E. 61st St., Chicago 60637 |
| PRESIDENT-ELECT | P. John Seward, 310 N. Wyman, Rockford 61101 |
| 1st VICE PRES. | Herschel Browns, 4600 N. Ravenswood, Chicago 60640 |
| 2nd VICE PRES. | G. W. Giebelhausen, Medical Arts Building, 1101 Main St., Peoria 61606 |
| SEC.-TREAS. | Audley F. Connor, Jr., 7531 Stony Island, Chicago 60649 |
| CHAIRMAN, BOARD OF TRUSTEES | Robert R. Hartman, 1515A W. Walnut, Jacksonville 62650 |

**House of Delegates**

| | |
|---|---|
| SPEAKER | Cyril C. Wiggishoff, 25 E. Washington, Chicago 60602 |
| VICE-SPEAKER | Robert P. Johnson, 108 Maple Grove, Springfield 62707 |

**Trustees**

| | | |
|---|---|---|
| 1st District | 1980 | John Ring, 511 E. Hawley, Mundelein 60060 |
| 2nd District | 1980 | Allan L. Goslin, 712 N. Bloomington, Streator 61364 |
| 3rd District | 1979 | Alfred Clementi, 675 W. Central Road, Arlington Heights 60005 |
| | 1980 | Raymond DesRosiers, 1044 N. Francisco, Chicago 60622 |
| | 1979 | Robert T. Fox, 2136 Robincrest Lane, Glenview 60025 |
| | 1979 | Jere Friedheim, 3050 S. Wallace, Chicago 60616 |
| | 1981 | Morris T. Friedell, 7531 Stony Island, Chicago 60649 |
| | 1981 | Henrietta Herbolsheimer, 5528 S. Hyde Park Blvd., Apt. 1202, Chicago 60637 |
| | 1981 | Lawrence L. Hirsch, 2434 Grace, Chicago 60618 |
| | 1980 | Harold J. Lasky, 55 E. Washington, Chicago 60602 |
| | 1980 | Richard N. Rovner, 645 N. Michigan, Suite 920, Chicago 60611 |
| | 1980 | Joseph Sherrick, 303 E. Superior, Chicago 60611 |
| 4th District | 1979 | Fred Z. White, 723 N. 2nd St., Chillicothe 61523 |
| 5th District | 1979 | P. F. Mahon, 808 E. Carpenter, Springfield 62702 |
| 6th District | 1981 | Robert R. Hartman, 1515A W. Walnut, Jacksonville 62650 |
| 7th District | 1979 | Alfred J. Kiessel, 1 Powers Lane Place, Decatur 62522 |
| 8th District | 1979 | James Laidlaw, 104 W. Clark, Champaign 61820 |
| 9th District | 1981 | Warren D. Tuttle, 203 N. Vine, Harrisburg 62946 |
| 10th District | 1981 | Julian W. Buser, 6600 W. Main, Belleville 62223 |
| 11th District | 1980 | Kenneth A. Hurst, 52 Bunting Lane, Naperville 60540 |
| 12th District | 1980 | Joseph Perez, 5670 E. State, Rockford 61108 |
| **Trustee-at-Large** | 1979 | George T. Wilkins, 3165 Myrtle, Granite City 62040 |

# *Highlights of the ISMS Annual Meeting April 2-5, 1978*

The 138th Annual Meeting of the Illinois State Medical Society convened April 2-5, 1978, at the Chicago Palmer House. Over 600 physicians, auxilians, medical students, guests and staff attended the House of Delegates as well as educational and issue-oriented meetings.

The Credentials Committee recorded attendance for the 1978 House of Delegates as follows:

| | First Session | Second Session | Third Session | Fourth Session |
|---|---|---|---|---|
| Officers & Trustees | 27 | 24 | 22 | 19 |
| Speaker & Vice Speaker | 2 | 2 | 2 | 2 |
| Down State Delegates | 70 | 75 | 74 | 74 |
| Chicago Medical Soc. Delegates | 80 | 53 | 65 | 68 |
| Intern/Resident | 0 | 0 | 0 | 0 |
| Student | 0 | 0 | 1 | 1 |
| TOTAL | 179 | 154 | 164 | 164 |

The first session of the House of Delegates was convened by Cyril C. Wiggishoff, M.D., Speaker of the House, at 1:00 p.m. on Sunday, April 2, 1978. Eugene P. Johnson, ISMS secretary-treasurer, conducted a brief memorial service for 152 members who had died in the past year.

Rules were suspended to accept two memorial resolutions from the floor, which were adopted unanimously. These resolutions commemorated Arkell M. Vaughn, M.D., a past president of ISMS, and Alan M. Taylor, M.D., vice president and former secretary of the Vermilion County Medical Society.

### Report of the Chairman of the Board of Trustees



Robert T. Fox, M.D., chairman of the ISMS Board of Trustees, reported that the Board had considered an unusually large number of resolutions referred from the 1977 Interim Session of the House. These would be considered under old business before the House of Delegates.

Dr. Fox's written report noted a wide span of activities. The Board had studied a proposal regarding possible confidentiality problems with Utilization Review and Professional Standards Review Organizations. In addition, the Illinois Congressional Delegation was urged to oppose national health insurance and consider a system of tax credits for the cost of medical services, drugs and health insurance.

Further, the Board worked successfully in pursuading IDPA to adopt CPT IV for all coding procedures and encouraged implementation through the AMA. CNA-Medicare has agreed to seriously consider the proposal. It was determined that state legislation requiring governmental third party payor use of CPT-IV is not feasible.

In accordance with ISMS administrative policy, the Board referred all resolutions suggesting legislative activity to the ISMS Governmental Affairs Council for review and comment.

In response to an Interim Session resolution, the Board asked the Illinois State Medical Inter-Insurance Exchange to provide information on the number of policyholders, claims filed in the past three years and claims disposition to interested county medical societies.

### Report of ISMS Governmental Health Program Reimbursement Committee

Robert R. Hartman, M.D., chairman, gave a supplemental annual report before the House of Delegates. He stated that the committee had worked extensively on IDPA-related issues. The Board of Trustees had endorsed in principle a proposed new IDPA reimbursement mechanism.

The system was formulated during ISMS-IDPA negotiations and will take effect if the General Assembly approves Governor Thompson's budget containing an additional $20 million for Medicaid payments to physicians. The $20 million increase resulted from an aggressive ISMS campaign to improve physician reimbursement levels.

The plan, which would take effect July 1, provides that physicians would be reimbursed at the *greater* of: (1) 70% of the 1977 calendar

year average statewide charge per procedure; or (2) IDPA's current statewide maximum. *In no case however, would a physician receive more than his billed charges or less than what he currently is being paid.*

While falling short of prevailing UCR charges, the new system will provide some increase and should eliminate the inherent discrimination against physicians who have participated in



*Governmental Health Program Reimbursement Committee Chairman Robert R. Hartman, M.D. (R) shakes hands with Robert T. Fox, M.D., chairman of the ISMS Board of Trustees as ISMS President George T. Wilkins Jr., M.D., looks on. Doctor Hartman was elected to serve as Doctor Fox' successor at the post-convention board of trustees meeting.*

Medicaid for many years. It should also remove inequities stemming from geographic location of practices.

Dr. Hartman's written report to the House noted that the ISMS Medicaid Membership Service Program had handled 207 complaints and recovered $154,331.72 for members since its inception June 6, 1977. Members of the Governmental Health Program Reimbursement Committee have worked in a number of other areas, including confidentiality, and IDPA recognition of legally constituted medical corporations and other groups.

**Special Reference Committee**

Speaker of the House Cyril C. Wiggishoff, M.D., appointed a special reference committee to consider 38 late resolutions relating to cost containment.

At its first session the House accepted a resolution from the floor commending Illinois legislators, IDMHDD and Robert deVito, M.D. for resolution of the permit physician question and calling a halt to dual licensing of physicians in state mental health facilities.

**Finance Committee Slide Presentation**

Alfred Clementi, M.D., chairman of the ISMS Finance Committee, presented the next report. "Your Board of Trustees is recommending a dues increase effective in 1979," he told the House. "Because of the importance of this matter, the Board asked me to present an overview of the Society's finances, beginning with the last dues increase and running through our projections for the next five years."

At its 1972 annual meeting, Dr. Clementi reported, the House had voted a $25 dues increase, effective the following year, that set dues at the current $131 level. This figure included the $1 for liaison with students and physicians-in-training. The increase was tied to a system of allocations to—and withdrawals from—ISMS reserves, and was intended to maintain dues at that level for five years rather than make annual adjustments.

The Five-Year allocation program was planned to: (1) wipe out the fiscal '72 deficit in the first year; (2) contribute to the permanent reserve over the first three years; (3) add to the Benevolence Reserve during the first three years; and contribute to the Contingency Reserve for three years. It was anticipated, Dr. Clementi said, that these contingency funds would be used to help meet expenses during fiscal '76 and fiscal '77.

Doctor Clementi then related financial activities since 1973 on a year-by-year basis. Accumulative totals for the first four years had matched the plan exactly. Creation of ISMIS and other activities which had not been forseeable when the plan was formulated had an impact in 1976, he explained, when the budget fell $5,000 below targeted levels.

"1977 marked the end of the five-year dues maintenance plan," Dr. Clementi said. "We withdrew $50,000 from the contingency reserve set aside for use in fiscal '77 but still fell an estimated $36,000 below our projections. Among the reasons was the departure of IFMC which shared the rent for our headquarters offices and offset some staff salaries, and also a decline in Journal revenue.

In summary, he said, the five years spanned by the dues maintenance plan saw ISMS significantly expand activities while varying from its plan by only $36,000.

Doctor Clementi reported that the Board of Trustees had recognized the need for a dues increase effective this year but believed that it was unwise to raise dues for 1978 because of in-



*The annual ISMS Past Presidents' Dinner, was held on Saturday evening, April first, in the Whitehall Hotel. Doctor J. M. Ingalls served as master of ceremonies for the gourmet dinner in honor of immediate past president Joseph H. Skom, M.D. Pictured above are (standing l-r): J. M. Ingalls, Frank J. Jirka, Jr., C. J. Jannings, III, Edward Piszczek, J. Ernest Breed, Newton DuPuy, Fredric Lake, and Willard C. Scrivner. Seated, l-r: Caesar Portes, E. P. Coleman, Leo P. A. Sweeney, and H. Close Hesseltine.*

creases levied by numerous other segments of organized medicine. The Board realized that without a dues increase for the current fiscal year ISMS would encounter deficit spending.

The 1978 deficit, Doctor Clementi told the House, is projected to be $193,000. It is estimated that gross income will increase 3% over the revised 1977 anticipated income. Net operating income should hit $1.7 million after deducting allocations for AMA-ERF, Benevolence, ICCME and Journal subscriptions. It is also anticipated that expenditures will increase 10% over last year's revised budgeted figures, leaving the Society with the $193,000 deficit which, he added, is an undesirable, but expected, position.

Doctor Clementi pointed out that the Society was able to hold dues at $131 through adherence to the maintenance plan. At present, ISMS has gone one year beyond the plan with dues at the same level and the need for an increase is obvious.

"As you can see," Doctor Clementi said, "based upon a comparison with other major state societies' 1978 dues, an increase will not place ISMS dues at an unreasonable level. I wish to emphasize that other societies use all dues monies to meet operating expenses. They do not allocate funds to a Benevolence Program, or to support an organization similar to ICCME. ISMS has a smaller portion of the dues dollar available to meet operating expenses. On the basis of $108 for the general fund, ISMS ranks 50th among the 53 states and territorial units of the AMA."

"The Board of Trustees has carefully reviewed projections of income and expenditures to assess the Society's financial needs through 1983," Dr. Clementi told the House. "Based upon this evaluation, the Board is recommending a $70 dues increase effective next year that would set dues at $201. The recommended increase is tied to a five-year allocation program similar to the plan which expired last year. It is designed to cover a six percent annual increase in expenses: enough to offset inflation and allow for necessary program expansion. It will also build adequate reserves. This House has stated that the Society should maintain reserves equal to one year's operating expenses. That policy is sound business practice. Unfortunately, in 1978 that goal could not be met."

Doctor Clementi then turned to projected income and expenses for the next five years. He noted that income exceeds expenses until 1982, but falls short of anticipated expenses in 1983. The gap between income and expenditures from fiscal 1979 through fiscal 1982, he explained, is the key to maintaining the dues level in the fifth

year of the plan.

Doctor Clementi described plans for the funds. They will be used for the following purposes: (1) to retire the accumulated deficit in the first year; (2) to add a total of $200,000 to benevolence funds in the first three years, moving that fund closer to becoming self-sufficient; (3) to strengthen the permanent reserve by $400,000 over three years; and (4) to build the contingency reserve by $110,000 in the first four years. Then, in 1983, the $110,000 would be used to meet expenses and avoid a dues increase.

Doctor Clementi closed his report by stating that the Board of Trustees believed the $70 increase tied to this soundly structured five-year allocation plan "will insure the financial stability of the Society and also enable ISMS to effectively meet the expanding needs of its members."

The dues increase was approved in a later session of the House of Delegates.

**Reference Committees Convene**

Reference Committees convened immediately upon House adjournment Sunday afternoon. After hearings and debate, they met in executive sission to write reports to the House. Although most completed their work in 10-12 hours, Reference Committee G, which was appointed to hear 38 resolutions on cost containment, worked until 5:00 p.m., tuesday to complete its report.

The Reference Committee on Amendments to Constitution and Bylaws was chaired by E. K. DuVivier, M.D. Reference Committee A, chaired by David Petty, M.D., considered issues relating to officers, administration, finances and budgets. Governmental health programs and national health insurance proposals were discussed in Reference Committee B, chaired by John Hubbard, M.D. Chairman M. Barry Kirchenbaum, M.D., reported results of testimony relating to education, manpower and clinical medicine in Reference Committee C. Resolutions and reports on medical service and economic matters outside government programs were digested in Reference Committee D, whose chairman was William B. Frymark, M.D. In Reference Committee E, Chairman Raymond W. Nemecek, M.D., guided discussion of resolutions and reports relating to governmental affairs and medical-legal matters. Kenneth Kaufman, M.D., chaired the hearing on public relations, membership and miscellaneous business in Reference Committee F.

Reference Committee G was appointed by the Speaker in response to many late resolutions concerning cost containment. Questions about the AMA-established National Commission on the Cost of Medical Care prompted most of these resolutions. Those recommendations will be considered at the June meeting of the AMA House of Delegates. The Resolutions brought before Reference Committee G were intended to elicit delegate opinion for the information of the Illinois AMA Delegation. This Reference Committee spent many long hours debating proposals.

The National Commission on the Cost of Medical Care (NCCMC) had released findings and recommendations in booklet form last December. Copies were widely distributed. Some specific sections had been reviewed by various ISMS councils and committees. Reference Committee G Chairman J. M. Ingalls, M.D., explained that the NCCMC report was frequently found to be ambiguous, and presents issues affecting many aspects of ISMS policy. Any action taken by the ISMS House would become policy. Time constraints had not allowed for the usual channels of consideration for proposed policy changes. Members of the reference committee and ISMS officers needed a mechanism to allow for debate on these issues. But the forum could not constitute a final consensus of the House, because adequate preparation had not been possible.

A second problem was the fact that some resolutions dealt with issues of national scope, beyond the purview of ISMS implementation.

For this reason, the House voted to refer all cost containment recommendations to the Board of Trustees for further study and report of findings at the 1978 Interim Session. When appropriate, the House referral would include a nonbinding "with favor" clause to indicate the House's initial response to the resolutions. These tentative reactions were intended to aid the AMA delegates in carrying forward ISMS opinion. They were, however, subject to further study and debate at the Interim Session.

**ISMS Workshop on Alcoholism Treatment**

The ISMS Committee on Alcoholism and Drug Dependence, supported by a grant from the IDMHDD Division of Alcoholism, presented a special workshop.

Henry Rosett, M.D., an associate professor of psychiatry affiliated with the Boston University School of Medicine Maternal Health and Child Development Program, discussed prevention of

the fetal alcoholism syndrome. His presentation included a series of slides depicting the historic development and spread of FAS.

Charles H. Kramer, M.D., director of family studies at Northwestern Memorial Hospital Institute of Psychiatry and professor of psychiatry and behavioral science at Northwestern University Medical School, discussed "Alcoholism and the Family." He presented mechanisms and criteria in family therapy, demonstrating that dynamics within the family can sometimes aggravate a pre-existing condition.

A film produced by the American Hospital Association with the support of a grant from HEW was also presented at the workshop. "Cause the Effect? Affect the Cause?" dealt with the attitudes of health care professionals in dealing with alcoholics, and the clear effect of attitudinal adjustment on treatment outcome.

### "A Critical Difference"

The above-captioned documentary film was shown on Monday morning through the courtesy of the ISMS Council on Public Relations and Membership Services. The film underscored the importance of maintaining the practice of medicine within the private sector. It was designed for presentation to civic clubs and other non-medical groups, and was shown to encourage physicians to work for its inclusion at meetings in their communities. The film can be obtained through the Council for local showings. County Medical Societies can borrow the film for appropriate community groups or purchase it outright through the Council.

### ICCME Workshop

The annual meeting of accreditation examiners for the Illinois Council on Continuing Medical Education focused on evaluation. The Council promulgates criteria for hospital program CME accreditation under the aegis of the ISMS Council on Education and Manpower. Examiners evaluate the quality of programs in continuing education sponsored by hospitals applying for accreditation. Their annual meeting affords an opportunity to re-examine criteria and on-site review methods.

At the workshop, three fictional hospital applications were reviewed by teams of examiners who played the roles of CME hospital planners and examiners in the on-site confrontation. Interactions in role-playing provoked extensive discussion after the exercise.

### Fifty Year Club Honors Special Member

The ISMS Fifty Year Club annual luncheon featured a special member this year. Tolbert F. Hill, M.D., the oldest living Illinois physician, received a plaque and special pin commemorating 80 years of medical practice from ISMS Vice-President Theodore Grevas, M.D. Dr. Tolbert is 104 years old, and retains membership in the Sangamon County Medical Society. He is the second of four generations of physicians, and is said to have delivered 2500 babies during his medical career. Doctor Hill graduated from Rush Medical College in 1896, and opened his office in 1898 in Athens, Illinois, where he still resides.



*ISMS Vice President Theodore Grevas, M.D., (1) gives special plaque to Tolbert F. Hill, M.D., the oldest living Illinois physician. Doctor Hill is the first member to receive an eighty-year pin from ISMS.*

Harold W. Sofield, M.D., served as speaker for the meeting, where 89 new members were inducted into the club. (The Fifty Year Club now boasts 820 Illinois physicians who graduated from medical school at least fifty years ago.) Doctor Sofield urged his fellows to participate in the democratic process. Pointing out that they now had time to apply valuable expertise in community service, he urged that they become involved in supporting qualified candidates to public office.

He went on to discuss the benefits of membership in the American Retired Physicians Association. The ARPA, Dr. Sofield explained, functions to serve the needs of physicians planning retirement, retired physicians and spouses of deceased physicians. They can help individuals find part-time employment utilizing their expertise

on a for-pay or volunteer basis. As a physician-advocate group, he said, their goal is to enhance the quality of life after retirement.

New members of the fifty year club include Jacob E. Reisch, M.D., 1970-76 ISMS secretary treasurer and J. Ernest Breed, M.D., 1971 ISMS president.

### IMPAC Wins National Awards

Pam Taylor, chairman of the Illinois Medical Political Action Committee, presented her annual report before the House of Delegates when the second session opened at 2:00 p.m., on Monday, April 3.

Mrs. Talyor reported that IMPAC had enjoyed another great year, both in membership enrollment and voluntary contributions. In the March 18 primary election, 115 of the 129 candidates supported by IMPAC had been slated: a 90% success rate. Mrs. Taylor also reported that membership had increased in 10 of the 12 Illinois districts, bringing a total 5% upswing in IMPAC membership representing over 50% of all ISMS members. Membership includes 5,542 physicians, 5,348 spouses and 64 sustaining members.

Rex E. Kenyon, M.D., chairman of the AMPAC Board, presented two first place awards to Mrs. Taylor. IMPAC was first nationally in total contributions to AMPAC in joint funding activities and also in largest membership increase over the prior year. Mrs. Taylor also accepted an award for the largest total female members given to the ISMS Auxiliary.



*Rex Kenyon, M.D., chairman of the AMPAC Board, gives special award to IMPAC chairman Pam Taylor.*

Mrs. Taylor closed her report with notes of appreciation to ISMS members and the hard-working members of the IMPAC Council. Progress, she said, should be an incentive to greater efforts. Mrs. Taylor, ending her term as IMPAC chairman, suggested that membership drives might now turn to specialty groups. "Let's have 20,000 members," she urged, "by 1980."

### AMA-ERF Check Presented

ISMS President George T. Wilkins, M.D., introduced Leo Henikoff, M.D., acting dean of Rush Medical College, and presented a check representing this year's contribution from the American Medical Association Education and Research Foundation to Illinois medical schools. Dr. Henikoff accepted the check as the representative of the Illinois Council of Medical School Deans. The check, in the amount of $137,102.13, will be distributed among the Illinois medical schools as follows:

| | |
|---|---|
| Rush Medical College, Chicago | $11,149.18 |
| University of Chicago, The Pritzker School of Medicine | 12,808.62 |
| Northwestern University Medical School of Chicago | 29,889.61 |
| University of Illinois College of Medicine Foundation, Chicago | 10,674.22 |
| Chicago Medical School | 15,687.80 |
| Stritch School of Medicine of Loyola University, Chicago | 21,157.92 |
| Southern Illinois University School of Medicine Foundation, Springfield | 7,164.18 |
| Chicago College of Osteopathy | 147.18 |
| Southern Illinois University Foundation, Carbondale | 254.18 |
| University of Illinois Foundation, Abraham Lincoln Campus | 8,667.18 |
| University of Illinois Foundation, Champaign | 1,877.18 |
| University of Illinois Foundation, Metro Campus | 6,294.18 |
| University of Illinois, Rockford School of Medicine Foundation | 4,442.18 |
| University of Illinois, Peoria School of Medicine Foundation | 6,888.52 |

Dr. Henikoff extended appreciation to ISMS membership and to the ISMS Auxiliary.

### CME Examiners Receive Awards

At the second House session, Robert T. Fox, M.D., chairman of the Board of Trustees, presented certificates to Illinois accreditation examiners who review hospital applicants for Category 1 continuing medical education accreditation. The examiners included 27 physicians, three Ph.D.'s and one osteopath, who visit nominee hospitals, review their applications and recommend action to ISMS.




*Jack L. Gibbs, M.D., (left) introduces members of the ISMS delegation to the American Medical Association.*

**Hamilton Teaching Award Presented**

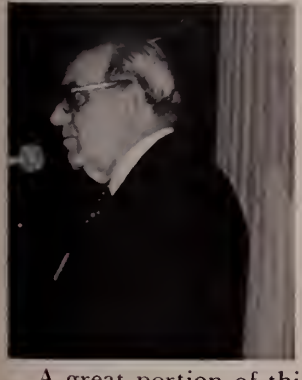
Fred Z. White, M.D. representing the Interstate Postgraduate Medical Association of North America, presented a special award to George E. Block, M.D. before the House of Delegates.

Dr. Block is professor of surgery and coordinator of education in surgical oncology at the University of Chicago Pritzker School of Medicine. A Yorkville resident, he is past president of the Chicago Surgical Society and former councilor of the Central Surgical Association. He is certified by many medical groups, including the American Association for Cancer Education, the American Gastroenterological Association and the American Geriatric Society.

Dr. White noted the many honors awarded Doctor Block, adding that he had been a central figure in UC surgical education for over a decade. Dr. Block thanked the delegates for the coveted award, and noted one omission. "I accept this award also on behalf of my wife and son," he said, "without whose patient understanding I could have accomplished nothing."

The Edwin S. Hamilton Teaching Award, named for ISMS' 1962 president, is given to an individual selected by the ISMS Council on Education and Manpower for outstanding contributions to medical education.

**Report of the Executive Administrator**



ISMS Executive Administrator Roger N. White noted intense activity and accelerated change in his annual report to the House. The new Springfield office is scheduled to open July 15, he said, and new ISMIS offices opened this winter.

A great portion of this year's efforts had been expended to correct unfair IDPA audit procedures. "We've worked to help our members," Mr. White said, "and against unfair IDPA accusations of over-utilization." Another area of intense study and interpretation, Mr. White said, is the position of ISMS lobbying efforts under the new Legislative Review Act.

Mr. White's written report noted a number of organizational changes in ISMS staff services. The Planning and Priorities Committee had recommended expanded services to specialty societies and a new division had been created for that purpose. The Board of Trustees authorized services for the Illinois Academy of Pediatrics. (ISMS already provides administrative services for the Illinois Psychiatric Society, Illinois Association of Ophthalmology, and Illinois Society of Internal Medicine). Mr. White also noted that a former division was divided in two: the Division of Medical Service and the Division of Field Services.

Mr. White noted a recent favorable evaluation of computer services by an outside consultant. He briefly discussed reasons for the dues increase, and closed with his heartfelt thanks to the delegates, trustees and council and committee members for their constant assistance.

**Report of the Illinois Delegation to the AMA**

Jack L. Gibbs, M.D., chairman of the ISMS delegation to the American Medical Association, assumed the podium to introduce the ISMS delegation to the AMA House. Dr. Gibbs thanked them for a year of hard work and loyal effort.

AMA delegation elections were held at the close of the annual meeting. The delegation now includes Herschel Browns, Howard C. Burkhead, Theodore Grevas, Morgan Meyer, Joseph H. Skom, Fred A. Tworoger, and Chairman Jack L. Gibbs, each of whom is an incumbent. Doctors Allison L. Burdick, Jr., Alfred J. Faber, David S. Fox, Lawrence L. Hirsch, Joseph R. O'Donnell, John J. Ring and Charles K. Wells were

re-elected to another term as AMA delegates.

Dr. Gibbs also introduced the alternate delegates to the AMA who will complete their terms in 1979. They are Drs. Robert R. Hartman, Eugene P. Johnson, Lee Johnson, Maynard I. Shapiro, Andrew Thomson, Jr., Glen E. Tomlinson, Cyril C. Wiggishoff and George T. Wilkins. The following physicians were re-elected to another term as alternate delegate: Audley F. Connor, Henrietta Herbolsheimer, Robert P. Johnson, Eugene T. Leonard and Morris Friedell. Dr. Andrew J. Brislen, who was appointed to fill the position of Fredric D. Lake, was confirmed for the remainder of Doctor Lake's term. (Dr. Lake's departure was prompted by his election as delegate from a specialty society.)

Dr. Gibbs reported on outcome of 16 resolutions brought to the AMA from the Illinois delegation. He noted that, while the delegates have points of disagreement, one point finds total unanimity. "To do anything to weaken our national organization or to weaken our voice within that organization would be a serious mistake. We should continue to support unified membership and urge other states to do likewise."

## AAMA Reports Educational Activities



*Mrs. Vivian Kraft, president of the Illinois Society, AAMA.*

Mrs. Vivian Kraft, president of the Illinois Society, American Association of Medical Assistants, was introduced to the House by John Wright, M.D., chairman of the Advisory Committee to the AAMA. Dr. Wright noted that AAMA members mourned the death of Carl E. Clark, M.D., who had served as ISMS liaison to the AAMA for many years. He also urged that additional volunteer physician-advisors would be most welcome. Dr. Wright closed his statement by reading a special proclamation from Governor Thompson, declaring April 23-30 "Medical Assistant Week" in Illinois.

Mrs. Kraft's report emphasized that their primary goal is professional advancement to facilitate optimal services to physician-employers. Educational efforts toward this end had included two workshop seminars in preparation for the certified medical assistant qualifying exam. She noted several "Travel Courses" and other educational activities sponsored by the AAMA this year, and gratefully acknowledged ISMS speakers at several of these meetings. Her report closed with a note of appreciation. "Illinois Society looks forward," she said, "to continued growth and achievement through the support of ISMS."

## President's Valedictory



*Doctor Wilkins addresses the House of Delegates.*

ISMS President George T. Wilkins, Jr., began his address by stating that he had decided to suspend the traditional president's summary of activities to deal with a crucial subject: expanding governmental intervention in personal and professional life. "When you go to bed with the government," he said, "you get more than a good night's sleep." Dr. Wilkins focused his comments on the growth of governmental bureaucracy, noting that the U.S. population had increased 60 times between 1789 and 1974—while the size of the federal bureaucracy had ballooned by more than 8,000 times. "Today, one in every six American works for the government," he said.

In another illustration, Dr. Wilkins said that government spending accounted for 10% of national income in the 1920's of which ⅔ was spent at the state and local level. At present, it accounts for 40% of the national income—and ⅔ of that figure is spent at the national level.

Doctor Wilkins then turned to more positive trends in the recent past, pointing to "backpedaling on the national health insurance issue," as evidence of "more common sense and less centralization in government." He also found encouragement in recently reduced influence of labor unions and changes evident in viewpoints of the last decade's liberals. He quoted Steven Solman of the Rutgers University Eagleton Institute of Politics:

"In the 1960's the burden of proof against change rested with those accepting the status quo. In the 1970's the burden of proof rests with those who want change."

Doctor Wilkins went on the recall the ideals on which the U.S. was founded, and to demand a return to the tenets of participatory democracy.

"Politics is not a spectator sport," Dr. Wilkins

said. "To be effective you must come down out of the stands and involve yourself in the political process. You must talk, think and act politics. You must view your patients not only as patients but as voters. . . . I urge you to do all you can to make government work for its citizens, rather than citizens working for the government."

**President's Night**



*J. M. Ingalls, M.D. (1) and President George T. Wilkins, Jr., M.D., at the annual President's Night dinner.*

On Monday evening, April third, 322 persons attended the annual gala dinner honoring George T. Wilkins, M.D., ISMS President and also celebrating the Golden Anniversary of the ISMS Auxiliary. Mrs. Betty Szewczyk, ISMS Auxiliary President gave a welcoming toast and Dr. Wilkins spoke briefly. J. M. Ingalls, M.D., served as master of ceremonies for the program, which included music by Al Pierson and his Orchestra.

**Auxiliary Works for Immunization, Against TV Violence**



*ISMS Auxiliary President Betty Szewczyk reports to the ISMS House of Delegates.*

In her golden anniversary address, ISMS Auxiliary President Mrs. Betty Szewczyk cited a constancy in Auxiliary goals. When the Auxiliary was established in 1928, she told the House, the founders had promised to work for "Our Husbands, Our Homes, Our Community, Our Country." In 50 years of effort, Mrs. Szewczyk said, "Auxiliary's come a long way."

This year's theme "Teach the Children," was pursued with campaigns in communities and schools to educate youth about nutrition, safety, immunization and cardio-pulmonary resuscitation techniques. These programs extended to parents, of course, who were also able to learn about the effects of violence on television and methods to combat violent programming.

"Appreciate the Past, Anticipate the Future," was Auxiliary's motto this year and legislation provided a means toward that end.

Other educational themes included "Home Influences vs. Peer Pressure," and the assault of pseudo-religious cults on young persons. Communication was stressed in every area, Mrs. Szewczyk said, and Auxiliary publications had included four newsletters and a monthly page in the *IMJ*. Membership drives were also significant this year, Mrs. Szewczyk added, noting that ISMSA still looks forward to its first male member.

Auxiliary is, as always, concerned with philanthropic efforts, and both the ISMS Benevolence Fund and contributions to AMA-ERF had blossomed. Although final national totals for AMA-ERF have not yet been received, Chairman Mrs. Evelyn Hodes had reported that this year's contributions already exceed all previous year donations.

Mrs. Szewczyk concluded her report with a special vote of thanks to ISMS members, officers and trustees whose support and encouragement she said, had made Auxiliary possible.

**Public Affairs Luncheon**



*Don Hinderliter, M.D., ISMS Public Affairs Committee chairman, introduces the luncheon speaker.*

The ISMS Public Affairs Committee sponsored a complimentary luncheon for interested delegates and guests. Susan Bryant, a Washington, D.C., political consultant, gave the keynote talk on "Finding your Candidate." Stressing the importance of sincere political involvement, Ms. Bryant encouraged the guests to study nominees' positions and records. "And while you're looking for your candidate," she said, "don't forget to look in the mirror."

Ms. Bryant emphasized that the most productive political volunteers are those who either know their best skills and make them available or assist willingly in any capacity. She encouraged volunteers to communicate with the campaign coordinator or even to join the campaign steering committee in order to ensure that their skills are best utilized.

**IMPAC Sponsors Workshop**

The Illinois Medical Political Action Committee sponsored a workshop on political involvement on Tuesday afternoon, April 4. Honorable

George O'Brien, Congressman from the 17th District, addressed the group.

Representative O'Brien stressed the important role of physicians who thoroughly research their candidates and support them with conviction. He asked attendants to walk their precincts, sponsor coffees and wear buttons declaring the candidates of their choice.

The Congressman also asked physicians to consider political office. He joked that, as an attorney, he could report the results of public opinion polls determining that voters have greater confidence in doctors than in lawyers.

### David S. Fox, M.D., Inducted as 126th ISMS President

At the final session of the House on Wednesday, April 5, ISMS President-Elect David S. Fox, M.D., introduced his family to the House of Delegates. ISMS President George T. Wilkins, M.D., then assumed the podium to administer the oath of office.

Dr. David Fox' inaugural address centered on the health care cost crisis. "A large portion of the increase in health care costs can be attributed to general inflation and a variety of other external non-medically relevant factors," he said. Dr. Fox stressed his belief that "physicians are willing to support changes that will improve access to care and reduce costs without sacrificing quality."

Physician involvement, Doctor Fox said, ". . . can help to defuse government's drive to assume control of our profession and the health care system. . . . Demonstrated positive action will greatly improve the prognosis for American Medicine."

Dr. Fox discussed efforts of the AMA National Commission on the Cost of Medical Care, and also the National Steering Committee formed by the AMA, AHA and Federation of American Hospitals. "Some of the Commission's recommendations have stirred controversy," Dr. Fox said, "and others have raised anger. Support those you can; but remember, we must take a close look at our so-called 'rights' and be willing to make some changes if we, for instance, plan to ask labor or the insurance industry to give up first-dollar coverage . . . and if we plan to ask our patients to accept co-insurance."

Dr. Fox also reported on the Steering Committee's recommendations. The Steering Committee has proposed a 15-point plan for cost containment in hospitals that calls for action at the hospital staff level ". . . and I understand that later this month the Committee will focus on steps we can take in our individual practices. Here again, there will be some tough decisions ahead."

The National Committee requested that state steering committees be appointed to direct implementation of its recommendations. ISMS has responded to that request by designating the Society's Task Force on Cost Effectiveness as the group to spearhead the effort in Illinois.

"I've talked about a commission, a committee and a task force," he concluded, "these groups are leading medicine's assault on the cost problem. But the key to winning the battle is the individual physician. . . . As your president, I pledge to vigorously promote reasonable and workable cost-effective programs . . . and to publicly denounce those schemes which place the value of the dollar above quality care for our patients."

### SBS and RPS Elect New Officers

The ISMS Student Business Session met on April 1 with a Medical Legal Seminar entitled "Law, Litigation and Medicine." The program centered on the application of basic law concepts in areas including medical negligence and informed consent.

In their afternoon business meeting, the SBS elected their new officers. Daniel R. Shirey was elected chairman and W. Joseph Ketcherside will serve as vice-chairman this year. The other officers are: Jerome Cohen, secretary, David Aizuss and Jason Chao, delegate and alternate delegate and John Johnson, immediate past chairman.

The Resident Physician Section also elected a new Governing Council during the ISMS Annual Meeting. They are as follows:

Ira Isaacson, M.D., chairman, Michael Sadove, M.D., vice-chairman and treasurer, Linda Hughey, M.D., secretary and editor, James DeBord, M.D., delegate and Anthony Savino, M.D., alternate delegate.

### Some Special Resolutions

Eugene P. Johnson, M.D., received a special commendation for his work as ISMS Secretary-Treasurer and his devoted service "at all levels of organized medicine."

The House of Delegates also voted to commend Philip G. Thomsen, M.D., who is now retiring. Doctor Thomsen is a former trustee and ISMS president. His commendation noted that "physicians individually, throughout our State have vastly benefited from his efforts."

# Summary of Actions

# 1978 Annual Sessions

# of the House of Delegates

## REFERENCE COMMITTEE ON AMENDMENTS TO CONSTITUTION & BYLAWS

1. Rejected a proposed amendment to ISMS Bylaws which would have discontinued unified membership with AMA.
2. Amended the Bylaws to provide that resolutions submitted nine weeks prior to meetings of the House of Delegates will be listed in the Delegates Handbook and IMJ only by author and subject.
3. Amended the Bylaws to allow: (A) A suspended member to continue participation in ISMS-sponsored insurance programs; and (B) A member in good standing who resigns voluntarily by Dec. 31 to be reinstated within one year by paying all dues and assessments that fell due during the period his membership lapsed. If more than one year has elapsed since his resignation, he must apply as a new member. (Adopted in lieu of Res. 77N-1)
4. Approved an amendment: (A) Requiring resolutions to be *received* at ISMS headquarters four weeks prior to the House of Delegates meeting—rather than merely being *submitted* by that date; and (B) Transferring the late resolution approval function to the House Committee on Rules and Order of Business.
5. Approved creation by the House of an independent Judicial Panel to replace the Board of Trustees as the Society's appellate body on disciplinary matters, with appropriate bylaw amendments to be presented at the 1978 interim session of the House of Delegates. The panel shall consist of five ISMS members nominated by the President and elected by the House.
6. Amended the Bylaws to provide for an equitable composition of the Executive Committee to consist of eight members—four each from Cook County and downstate by providing for the Chairman of the Policy Committee to be a member of the committee only if the immediate past chairman of the Board is no longer a trustee.

## REFERENCE COMMITTEE A

1. Approved continued re-allocation of $10 of each member's 1979 dues normally allocated to AMA-ERF to the Illinois Council on Continuing Medical Education. Financial support for ICCME during the year to be provided from this allocation by the ISMS Board of Trustees based upon the needs as determined by the ISMS Finance Committee. ICCME was directed to submit to each annual meeting of the House of Delegates a financial report indicating

major sources of income and categories of expenditure as well as a copy of its budget.

2. Adopted a policy statement on violence developed by the Board of Trustees in accordance with instructions from the previous House of Delegates.

3. Increased the annual honorariums for the President and Chairman of the Board to $11,000 each and the President-elect to $4,000. The House also instructed the Finance Committee to evaluate officer honorariums on an annual basis and recommend appropriate changes to the Board of Trustees for consideration and action, reporting any changes to the House.

4. Rejected a proposal to allocate one AMA delegate position and one alternate delegate position to a resident physician member.

5. Advised the AMA delegation to maintain its present clear and ethical position on the doctor-patient relationship, as represented by the current Principles of Medical Ethics, resisting the increasing pressure which government intervention is placing on this relationship.

## REFERENCE COMMITTEE B

1. Directed the Board of Trustees to appoint a committee consisting of one member from each federally designated PSRO area in Illinois to improve communications between PSROs, review and evaluate PSRO activity and report back to the Board.

2. Rejected a proposal to establish an ad hoc committee on health planning to monitor HSA activities because ISMS already has such committee and the ISMS field service already is engaged in this activity.

3. Directed AMA Delegation to urge AMA to request of HEW that when a guideline discussion is presented in the Federal Register, the source of information should be specifically identified.

4. Instructed the AMA Delegation to introduce a resolution in the AMA House directing its representatives to the National Commission on the Cost of Medical Care to seek to incorporate into the commission's recommendations the economic impact of regulations promulgated by HEW. (ISMS subsequently learned that the commission has been disbanded. As a result, no changes or additions will be made in its report.)

5. Adopted the position that HR 1818 violates the AMA's 17 guidelines for any comprehensive health insurance program in at least five areas. (Adopted in lieu of Res. 77N-49)

6. Agreed to oppose suggested changes in P.L. 93-641, (National Health Planning Act of 1974) which would: (A) Extend Certificate of Need legislation to physicians' offices; (B) Reduce the number of physicians on HSA Boards; and (C) Extend preferential treatment to HMOs under Certificate-of-Need legislation.

## REFERENCE COMMITTEE C

1. Agreed to petition the American Medical Association to continue and expand its action to assure that basic courses in nutrition are presented as part of the core curriculum in all accredited medical schools and to encourage fostering of clinical nutrition education at the postgraduate level.

2. Rejected a proposal that ISMS proclaim the Right to Life to be man's most important right, because the House believes the issue involves moral and ethical considerations which must be decided on an individual basis.

3. Opposed the retroactive application of Title VI of P.L. 94-484, as amended, to duly licensed foreign physicians who have approved third preference petitions prior to Jan. 10, 1977 by:

   (A) Recommending to the Department of HEW that it should accept previous FLEX and/or state medical board licensure examinations as equivalent to the Visa Qualifying examinations and Parts I and II of the National Board examinations;

   (B) Recommending to HEW that foreign medical graduates coming to the

United States under the auspices of this new law not be limited to a two-year post-graduate program, but should be permitted to remain for the duration of their original post-graduate training;

(C) Instructing the AMA delegation to introduce a similar resolution at the AMA.

4. Affirmed that the results of recertification examination not be the sole criterion used by hospital governing bodies and hospital medical staffs in the granting of clinical privileges. (Adopted in lieu of Res. 77N-25)

## REFERENCE COMMITTEE D

1. Opposed the new Blue Cross/Blue Shield rider which provides that the Blues have "power of decision as to medical necessity of services and supplies, including hospitalization, over and above the judgment of the treating physician." The House also agreed to register this opposition with the Illinois Department of Insurance, seek abolition of this provision and urge AMA to seek similar action.

2. Rejected a proposal to adopt additional policy on hospital enforcement of regulations making professional liability insurance a condition for staff appointments. The House believed this matter is adequately handled by existing policy.

3. Adopted the position that "Blue Cross/Blue Shield case-by-case adjudication represents utilization review and is contrary to ISMS policy."

4. Agreed to encourage ISMS members to report in truthful and timely basis unfavorable experience with third-party payers so that these experiences can be published in the IMJ "Membership Forum," over the signature of the individual physician.

5. Rejected a proposal that ISMS become involved in recommending new approaches to blood donor recruitment.

6. Adopted the position that "ISMS shall not facilitate the development of governmentally-supported HMO or similar practice alternatives which would be discriminatory against the private solo or private group practice of medicine." This position will be brought to the AMA for similar action.

7. Agreed that if a physician is unable to continue the care of his patient after transfer either to hospital or nursing home, the physician should make special provisions for transfer of the patient and his medical information to a specific identified physician receiving that patient.

## REFERENCE COMMITTEE E

1. Referred to the Board of Trustees a proposal that a physician be deemed unethical who repeatedly renders testimony in malpractice litigation for monetary rewards, which may constitute an important part of his income.

2. Referred to the Board of Trustees a proposal that ISMS seek to prevent extension of P.L. 93-641 (National Health Planning Act of 1974) by an extensive lobbying and public relations campaign and that ISMS instigate development of state funded and state staffed local health planning agencies.

3. Encouraged ISMS to strengthen its Key Man Program related to state and federal legislators and urged AMA to increase its efforts to develop expeditiously a Key Man program for all federal legislators.

4. Encouraged state legislation to allow physicians' liens in Workmen's Compensation cases.

5. Adopted the position that, "as mandatory continuing medical education applies to the licensure of a physician, it should equally apply as mandatory continuing legal education for the lawyer and as utilization review applies to medical care in the hospital, it should also apply to the judicial process in the courts." The House also reaffirmed the intent of Resolution 77A-95, which directed that a legislative effort be made to seek statutory correction of legal abuses that have contributed to the dilem-

na of Illinois courts and the professional malpractice problem.

6. Supported the concept that optometric services in all VA facilities be directly responsible to their respective departments of ophthalmology. This position will be communicated to directors of all Illinois VA facilities, and the Chief Medical Director of the Veterans Administration. In addition, AMA will be requested to seek repeal of that section of P.L. 94-581 authorizing creation of separate optometric services.

## REFERENCE COMMITTEE F

Rejected a proposal that ISMS undertake a new survey of its members to determine the doctors' views on when life begins.

## REFERENCE COMMITTEE G

Referred to the Board of Trustees for further study all resolutions regarding the Summary Report of the National Commission on the Cost of Medical Care. Some of the resolutions were referred with favor; others with no comment, with instructions to the Board to report back to the House of Delegates at the 1978 Interim Session.

Extensive testimony was heard by a special reference committee organized to consider resolutions relating to the commission report. The House action was designed to provide the AMA delegation with guidance, but avoid binding the delegation to a specific position on any of the commission's recommendations.

Actions on these and all other resolutions considered by the 1978 annual meeting of the House of Delegates are listed in the report entitled "Actions on Resolutions."

## OLD BUSINESS

The House took the following action on resolutions introduced at the 1977 annual meeting and referred to the Board of Trustees for study and recommendation:

*77A-30*—Adopted an amendment to Article X of the Constitution to allow the Constitution to be amended at either an annual or interim meeting of the House of Delegates.

*77A-28*—Adopted this statement regarding discrimination in medical school admissions: "The Illinois State Medical Society favors admission of students into medical schools on the basis of their ability to be good medical students and physicians."

*77A-43*—Adopted an amendment to Article VI of the Constitution which removes the specific number of trustees from the list of society officers, substituting "such trustees and other officers as the bylaws may provide."

*77A-98*—Adopted operating procedures for official appearances of officers, trustees and members of AMA delegation.

The House took the following actions on 1977 Interim Session resolutions which were referred to the Board of Trustees for study and recommendation.

*Adopted substitute resolutions in lieu of:*

77N-25—Withholding Hospital Privileges—(See Item 4 under Reference Committee C)

77N-49—Comprehensive Health Care Insurance—(See Item 5 under Reference Committee B)

77N-1—Amendment to Chapter X—(See Item 3 under Reference Committee on Amendments to Constitution and Bylaws)

*Deferred:*

77N-50—Shortage of Health Care Personnel and Facilities

77N-52—Health Care Institutions Functioning Seven Days

*Rejected:*

77N-9—Catastrophic Health Insurance

77N-17—Medicare Weaknesses, Fallacies and Liabilities Reinforcing Opposition to Compulsory Federally Mandated Health Insurance

77N-19—Shortcomings of Medicare and Public Aid Projected to National Health Insurance

*Not Introduced:*

77N-14—Limited License Physicians in the Department of Mental Health

# Actions on Resolutions
# April, 1978 Annual Meeting
# House of Delegates

| *Number* | *Introduced By:* | *Subject* | *Action* |
|---|---|---|---|
| **Reference Committee on Constitution & Bylaws** | | | |
| 78A-1 | Loren M. Boon | Release from Required Unified Membership with AMA | Rejected |
| 78A-13 | Lawrence L. Hirsch | Amendment of Bylaws, Chapter IV, Section 11—Publication of Resolutions | Adopted |
| 78A-27 | James Laidlaw | Amendments to Chapter I, Section 3—Tenure and Termination—Chapter X, Section 10—County Societies | Adopted as amended in lieu of 77N-1 |
| 78A-28 | James Laidlaw | Amendment to Section 11, Chapter IV, of the Bylaws—Introduction of Resolutions | Adopted |
| 78A-30 | A. Everett Joslyn | Revisions in Disciplinary Procedures | Adopted |
| 78A-83 | John Ring<br>Herschel Browns<br>Lawrence Hirsch<br>Allan Goslin | Executive Committee Structure | Adopted |
| **Reference Committee "A"** | | | |
| 78A-6 | William M. Lees | ICCME Funding | Adopted as amended |
| 78A-9 | James Laidlaw | Implementation of Substitute Resolution 77N-30 | Adopted as editorially changed |
| 78A-20 | Alfred Clementi | Increase in Honorariums for President, President-Elect, and Chairman of the Board of Trustees | Adopted as amended |
| 78A-38 | Robert L. Cavens | Resident Delegate from Illinois to AMA House of Delegates | Rejected |
| 78A-81 | R. Kent Swedlund | Resolution Concerning Changes in AMA Code of Ethics | Adopted as amended |
| **Reference Committee "B"** | | | |
| 78A-14 | James P. Campbell | Illinois State Medical Society Ad Hoc Committee on PSROs | Substitute adopted |
| 78A-15 | James P. Campbell | Illinois State Medical Society Ad Hoc Committee on Health Planning | Rejected |

| *Number* | *Introduced By:* | *Subject* | *Action* |
|---|---|---|---|
| 78A-16 | Joseph R. O'Donnell | Proposed National Guidelines for Health Planning by Department of HEW | Adopted |
| 78A-17 | Joseph R. O'Donnell | Economic Impact Analysis and the Cost of Medical Care Summary Report | Adopted |
| 78A-21 | James Laidlaw | Amendments to HR 1818 | Adopted as amended in lieu of 77N-49 |
| 78A-70 | P. John Seward | Proposed Changes in Public Law 93-641 | Substitute adopted |
| **Reference Committee "C"** | | | |
| 78A-3 | C. J. Jannings, III | Basic Courses in Nutrition | Substitute adopted |
| 78A-7 | H. Frank Holman | Formulating Human Rights Priorities | Rejected |
| 78A-10 | James Laidlaw | Unfairness of Public Law 94-484, Title VI | Adopted as amended |
| 78A-11 | Kenneth Hurst | Withholding Hospital Privileges | Adopted as amended in lieu of 77N-25 |
| **Reference Committee "D"** | | | |
| 78A-2 | David A. Rothstein | Blue Cross/Blue Shield Rider | Substitute adopted as editorially changed |
| 78A-4 | Samuel J. Schimel | Professional Liability Insurance as a Condition for Staff Appointments | Rejected |
| 78A-5 | David A. Rothstein | Utilization Review by Blue Cross/Blue Shield | Substitute adopted |
| 78A-19 | Michael R. Treister | Unfavorable Physician Experiences with Insurance Companies | Substitute adopted as editorially corrected |
| 78A-24 | William B. Frymark | Multiple Approaches to Blood Donor Recruitment | Rejected |
| 78A-25 | Thomas W. Stach | Solo Practice | Substitute adopted |
| 78A-36 | Kenneth Hurst | Continuity of Care | Adopted |
| **Reference Committee "E"** | | | |
| 78A-8 | Ernest F. Adams | Cost and Ethics of Malpractice Testimony | Referred to B of T |
| 78A-12 | Melvin Freedman | Substitute Proposal for PL 93-641, National Health Planning & Resource Development of 1974 | Referred to B of T |
| 78A-18 | Thomas W. Stach | Key Man Program | Adopted as amended |
| 78A-23 | Michael R. Treister | Workmen's Compensation | Adopted |

| *Number* | *Introduced By:* | *Subject* | *Action* |
|---|---|---|---|
| 78A-29 | Wayne N. Leimbach | The Illinois State Medical Society as a Catalyst to Promote a Dialogue between the Illinois State Legislature and the Illinois Supreme Court in an Effort to Promote Legal Reform as One Step Toward Curbing Escalating Medical Costs | Substitute adopted as amended |
| 78A-79 | Paul Mahon | Optometric Services in VA Hospitals | Adopted as amended |

**Reference Committee "F"**

| | | | |
|---|---|---|---|
| 78A-26 | H. Frank Holman | Determination of When Life Begins | Rejected |

**Reference Committee "G"**

All resolutions considered by this Reference Committee pertained to the Summary Report of the National Commission on the Cost of Medical Care. They all were referred to the Board of Trustees for study and report back to the House of Delegates at its Interim Session, November, 1978.

| | | | |
|---|---|---|---|
| 78A-31 | Theodore Grevas | Recommendation 7 of the Nat'l. Commission on the Cost of Medical Care | Substitute referred |
| 78A-32 | Theodore Grevas | Recommendation 12 of the Nat'l. Commission on the Cost of Medical Care | Substitute referred with favor |
| 78A-33 | Theodore Grevas | Recommendation 16 of the Nat'l. Commission on the Cost of Medical Care | Referred |
| 78A-34 | Theodore Grevas | Recommendation 17 of the Nat'l. Commission on the Cost of Medical Care | Referred |
| 78A-35 | Theodore Grevas | Recommendation 40 of the Nat'l. Commission on the Cost of Medical Care | Referred |
| 78A-40 | H. Herbolsheimer | Recommendation 8: Assessment & Assurance of Quality | Referred |
| 78A-41 | Kenneth A. Hurst | Recommendation 25: Criteria and Use of Practice Evaluation Techniques | Substitute as editorially changed referred with favor |
| 78A-42 | H. Herbolsheimer | Recommendation 28: Inappropriate Medical Care | Substitute referred with favor |
| 78A-43 | Kenneth A. Hurst | Recommendation 31: Preventive Services | Substitute referred with favor |
| 78A-44 | H. Herbolsheimer | Recommendation 32: Multiphasic Health Evaluations | Referred |
| 78A-45 | Kenneth A. Hurst | Recommendation 46: Health & Patient Education | Referred with favor |

| *Number* | *Introduced By:* | *Subject* | *Action* |
|---|---|---|---|
| 78A-46 | Paul F. Mahon | Recommendation 14: Incentives to Provide Appropriate Care | Referred |
| 78A-47 | Paul F. Mahon | Recommendation 26: Diagnostic Findings | Referred |
| 78A-48 | Paul F. Mahon | Recommendation 42: Technology Assessment & Information Dissemination | Referred |
| 78A-49 | Paul F. Mahon | Recommendation 45: Research Toward Cost-Saving Innovations | Referred |
| 78A-50 | Allan L. Goslin | Recommendation 1: Economic Incentives in Purchasing Insurance & Health Plans | Referred |
| 78A-51 | Eugene Johnson | Recommendation 3: Fair Market Competition | Substitute referred with favor |
| 78A-52 | Allan L. Goslin | Recommendation 4: Alternative Financing Arrangements | Referred |
| 78A-53 | Eugene Johnson | Recommendation 6: Information on Alternative Health Care Plan Benefits | Referred |
| 78A-54 | Allan L. Goslin | Recommendation 9: Reimbursement Levels for Providers | Referred with commendation and favor |
| 78A-55 | Eugene Johnson | Recommendation 15: Utilization in Appropriate Settings | Substitute referred with favor |
| 78A-58 | H. Herbolsheimer | Recommendation 11: Reimbursement Restrictions | Substitute as amended referred with favor |
| 78A-59 | Alfred J. Kiessel | Recommendation 13: Incentives to Limit Bed Cacapity | Substitute as editorially changed referred with favor |
| 78A-60 | H. Herbolsheimer | Recommendation 18: Planning | Substitute referred with favor |
| 78A-61 | Alfred J. Kiessel | Recommendation 19: Certificate-Of-Need | Referred |
| 78A-62 | H. Herbolsheimer | Recommendation 20: Decertification | Referred |
| 78A-63 | Alfred J. Kiessel | Recommendation 23: Regional Centers | Referred |
| 78A-64 | H. Herbolsheimer | Recommendation 24: Capital Expenditure Limits | Referred |
| 78A-68 | Alfred J. Kiessel | Recommendation 22: Placement Review Criteria | Referred |
| 78A-69 | Alfred J. Kiessel | Recommendation 30: Defensive Medicine | Referred |
| 78A-71 | H. Herbolsheimer | Recommendation 21: Supply Guidelines | Referred |

| *Number* | *Introduced By:* | *Subject* | *Action* |
|---|---|---|---|
| 78A-72 | H. Herbolsheimer | Recommendation 33: Physician Supply | Referred |
| 78A-73 | H. Herbolsheimer | Recommendation 34: Professional Attractiveness | Referred |
| 78A-74 | H. Herbolsheimer | Recommendation 35: Loan Forgiveness & Scholarships | Referred |
| 78A-75 | H. Herbolsheimer | Recommendation 36: Recruitment from Underserved Areas | Referred |
| 78A-76 | H. Herbolsheimer | Recommendation 37: Family Practice | Referred |
| 78A-77 | H. Herbolsheimer | Recommendation 38: Curricula on Economics of Health Care | Referred |
| 78A-78 | Robert T. Fox | Recommendation 43: Limit Restrictions on Diffusion of New Technologies | Referred |

The following resolutions were considered by the House of Delegates without referral to a Reference Committee:

| | | | |
|---|---|---|---|
| 78A-80 | Morris Friedell | Permit Licenses for Physicians | Adopted |
| | Herschel Browns<br>Allan Goslin<br>Lawrence L. Hirsch<br>& John Ring | Commendation for Eugene P. Johnson, M.D. | Adopted |
| | George T. Wilkins, Jr.<br>David S. Fox | Commendation of Philip G. Thomsen, M.D. | Adopted |
| | James Laidlaw | Memorial Resolution—Alan M. Taylor, M.D. | Adopted |
| | Eugene P. Johnson | Memorial Resolution—Arkell Vaughn, M.D. | Adopted |

**Old Business**

As a result of Board of Trustees, Reports A, B, C, D, E, F, G, H, I, J, K, and L, the House of Delegates took the following actions on resolutions pending from the 1977 Annual and Interim Sessions:

| | | | |
|---|---|---|---|
| 77N-14 | George Lagorio | Limited License Physicians in the Department of Mental Health | Rejected |
| 77N-9 | Harry Darland | Catastrophic Illness & Injury Insurance | Rejected |
| Substitute 77N-25 | | Withholding Hospital Privileges | Adopted 78A-11 as amended in lieu of 77N-25 |
| 77N-17 | O. W. Pflasterer | Medicare Weaknesses, Fallacies & Liabilities Reinforcing Opposition to Compulsory Federally Mandated Health Insurance | Rejected |

| *Number* | *Introduced By:* | *Subject* | *Action* |
|---|---|---|---|
| 77N-19 | O. W. Pflasterer | Shortcomings of Medicare & Public Aid Projected to National Health Insurance | Rejected |
| 77N-49 | Robert L. Prentice | Comprehensive Health Care Insurance | Adopted 78A-21 as amended in lieu of 77N-49 |
| 77A-30 | Fred Z. White | Amendment to Article X of the Constitution | Adopted |
| 77A-4? | Fred Z. White | Amendment to Article VI of the Constitution | Adopted |
| 77N-50 | Robert L. Cavens | Shortage of Health Care Personnel & Facilities | Deferred |
| 77N-1 | James Laidlaw | Amendment to Section 11 of Chapter X | Adopted 78A-27 in lieu of 77N-1 |
| 77N-52 | Robert L. Cavens | Health Care Institutions Functioning 7 days | Deferred |
| Substitute 77A-28 | | Discrimination in Medical School Admissions | Adopted as amended |
| 77A-98 | George T. Mitchell | Policy Statements by ISMS Officers, Trustees, Members of AMA Delegation | Substitute adopted as editorially changed |


**COOK COUNTY**
**Graduate School of Medicine**

CONTINUING EDUCATION COURSES
STARTING DATES—1978

ADVANCES IN SURGERY, 5 days, May 8
SPECIALTY REVIEW NEPHROLOGY, May 8
SPECIALTY REVIEW RHEUMATOLOGY, May 8
SPECIALTY REVIEW ANESTHESIOLOGY, 6 days, May 14
SPECIALTY REVIEW OBSTETRICS & GYNECOLOGY, May 15
ADVANCES IN FAMILY MEDICINE, 5 days, May 15
REFRESHER COURSE IN DIAG. RADIOLOGICAL PHYSICS, May 15
SPECIALTY REVIEW HEMATOLOGY, May 15
SPECIALTY REVIEW INFECTIOUS DISEASE, May 15
RADIATION ONCOLOGY. 4½ days, May 22
GENERAL & DIAGNOSTIC RADIOLOGY, 5 days, May 22
CARDIOLOGY FOR THE INTERNIST, 2 days, June 8
CURRENT CONCEPTS IN MGT, IN COMMON NEOPLASMS, June 12
FLUIDS & ELECTROLYTES, 3 days, June 15
SPECIALTY REVIEW PEDIATRICS, July 10
ADVANCED PERIPHERAL VASCULAR SURGERY, 5 days, July 17
SPECIALTY REVIEW FAMILY PRACTICE, July 17

*Information concerning numerous other continuation courses available upon request.*

**Address:**
**REGISTRAR, 707 South Wood Street,**
**Chicago, Ill. 60612**


# *ISMS Travel Program*

Three of the ISMS travel programs scheduled for 1978 remain open for reservations. These include trips to Scandinavia (July 2-15); Imperial Europe (Aug. 30-Sept. 9) and the Eastern Mediterranean Air/Sea Cruise (Oct. 25-Nov. 7). Descriptive brochures will be mailed five months in advance. Reservations cannot be accepted without the official form printed in these brochures. Individuals outside a member's immediate family will be placed on standby status until all ISMS members have had reasonable time to make reservations. *Promotional expenses connected with these programs are paid for by the tour operator.* For further information, contact ISMS headquarters.













ALMEF HOUSE








ISE

NONPARTISAN

# IMPAC

**ILLINOIS MEDICAL POLITICAL ACTION COMMITTEE**
55 East Monroe Street
Chicago, Illinois 60603
312/782-1963

## MEET YOUR NEW IMPAC COUNCIL

### EXECUTIVE COMMITTEE

Herbert Sohn, M.D., Chairman - Chicago
George T. Mitchell, M.D., 1st Vice Chairman - Marshall
Robert T. Fox, M.D., 2nd Vice Chairman - Glenview
P. F. Mahon, M.D., Secretary-Treasurer - Springfield
Mrs. Alan Taylor, At Large - Danville

### TERMS EXPIRING 1979

Alfred J. Faber, M.D. - Northbrook
E. J. Jacobs, M.D. - Arlington Heights
Frank J. Jirka, M.D. - River Forest
James Laidlaw, M.D. - Champaign
William M. Lees, M.D. - Lincolnwood
Tassos Nassos, M.D. - Chicago
Edward Ragsdale, M.D. - Godfrey
Clifton L. Reeder, M.D. - Chicago
Willard C. Scrivner, M.D. - Belleville
Fred A. Tworoger, M.D. - Chicago

### TERMS EXPIRING 1980

James Cavanaugh, Jr., M.D. - Winnetka
Herschel Browns, M.D. - Chicago
Robert T. Fox, M.D. - Glenview
Theodore Grevas, M.D. - Rock Island
Earl Klaren, M.D., - Libertyville
P. F. Mahon, M.D. - Springfield
George T. Mitchell, M.D. - Marshall
Mrs. Alan Taylor - Danville
Mrs. John Van Prohaska - Chicago
George T. Wilkins, M.D. - Granite City

### TERMS EXPIRING 1981

Louis Dondanville, M.D. - Moline
Edwin L. Falloon, M.D. - Evergreen Park
Morris T. Friedell, M.D. - Chicago
Don Hinderliter, M.D. - Rochelle
John W. Ovitz, Jr., M.D. - Sycamore
Albert W. Ray, Jr., M.D. - Joliet
P. John Seward, M.D. - Rockford
Herbert Sohn, M.D. - Chicago
A. E. Steer, M.D. - Springfield
Philip G. Thomsen, M.D. - Dolton

Contributions are not limited to the suggested amount. Neither the Illinois State Medical Society nor the AMA will favor or disadvantage anyor based upon the amounts of or failure to make pac contributions. Copies of IMPAC & AMPAC reports are filed with and are available for purchase from the Federal Election Commission, Washington, D.C. Contributions are subject to the limitations of FEC regulations, Sections 110.1, 110.2 & 110.5. (Federal regulations require this notice.) IMPAC reports are also filed with the State Board of Elections, and are or will be avail for purchase from the State Board of Elections, 1020 South Spring Street, Springfield, Illinois 62704.

# *Abstracts of Board Actions*

*(Continued from page 342)*

- *Statute of Limitations:* Prohibit the filing of a suit more than two years after the date of the alleged act, except that a minor under the age of six would have until his eighth birthday to file suit.
- *Community Standard & Expert Witness Rule:* Requires that any expert witness: (1) Practice in a locality similar to that in which the alleged incident occurred; and (2) Must have practiced in the specialty relevant to the case within one year after the date of the incident.
- *Counterclaims/Malicious Prosecution:* Expands the definition of malicious prosecution to enable physicians to sue without the requirement of special damages and to permit the filing of such counterclaims in the original cause of action, without having to wait for a favorable verdict.

ISMS opposed a suggestion that surgicenters be permitted to purchase and dispense drugs in a manner similar to that of hospitals. The Board action was based upon these points: (1) The proposal deals only with the Controlled Substances Act and ignores other acts which affect this practice; (2) There is no provision for inventory control, locked security and the presence of a registered pharmacist on the premises; and (3) The proposal would have no effect on federal laws governing the dispensing of drugs which could be construed as superceding Illinois provisions.

The Society also will oppose any proposed statutory revisions which would preclude the ability of a physician to dispense medication.

## Nurses Performing Obstetrical Care

ISMS will oppose any action to amend Hospital Licensing Act regulations to permit nurses to perform obstetrical care. The Board action is designed to block any attempts by hospital-employed nurses to be allowed to perform independent obstetrical services.

## Staff Privileges For Podiatrists

ISMS will oppose any proposed changes in Hospital Licensing Act regulations that would require hospitals to grant independent staff privileges to podiatrists as a condition of hospital licensure.

## Continuing Medical Education

The ISMS Accreditation Committee—which had been a committee of the Council on Education and Manpower—was redesignated as a direct-reporting committee responsibile only to the Board of Trustees and staffed by ICCME personnel. At its February meeting, the Board agreed in principle to delegate to ICCME full responsibility for CME accreditation surveys and review. The change in the Accreditation Committee role will clarify the accreditation process, enabling organizations to deal exclusively with ICCME when seeking accreditation.

The Committee on Planning and Priorities was directed to study: (1) Administrative and financial structure of ICCME; (2) Methodology of CME; and (3) Relationship of CME and ICCME to the Society.

ISMS will urge ICCME to emphasize on its application materials the requirement that accredited institutions provide full disclosure of materials, methods, objectives and evaluation procedures of offered courses. ICCME also will be asked to inform accredited institutions of their responsibility for such disclosure when co-sponsoring CME programs with non-accredited institutions. National accrediting agencies also will be asked to insist on the same type of disclosure by institutions they accredit. The Board action was in response to a House of Delegates directive.

ISMS will petition the national Liaison Committee on CME (LCCME) to provide appropriate certificates which can be presented to accredited institutions in appropriate ceremonies. Currently, LCCME merely informs ISMS of institutions accredited and requests the Society to forward this information to the institutions.

The Society also will voice objection to LCCME over several of the national group's accreditation practices, including after-the-fact changes in rules, and failure to consult with state societies prior to changing rules.

### Cost Effectiveness

Reaffirming action taken at its last meeting, the Board designated the ISMS Task Force on Cost Effectiveness as the preferred state steering committee to implement cost control recommendations of the AMA-AHA-FHA National Voluntary Steering Committee. The Task Force was designated because it meets criteria for state committees laid down by the National Committee which includes representatives of the commercial health insurance industry, Blue Cross Assn., U.S. Chamber of Commerce and others. The ISMS Task Force also includes representatives of organizations other than those representing hospitals and physicians.

The Illinois Hospital Assn. has chosen to rely upon an "in-house" committee to implement the National Committee's recommendations. The Board agreed to appoint—when requested—physician consultants to the IHA committee, and will ask IHA to submit progress reports on its cost containment efforts to the Task Force.

### Multiphasic Screening Programs

ISMS chose to take no position on a mobile multiphasic screening program being conducted by American Health Profiles (AHP) on behalf of the Illinois Agricultural Association. AHP had asked ISMS to encourage county society cooperation in the screening. Instead, ISMS will: (1) Inform county societies about the operations of multiphasic screening vans and current AMA and ISMS positions on the subject; and (2) Discuss with the Illinois Department of Public Health the monitoring of the multiphasic screening programs.

### AMA Advertising Campaign

ISMS will provide copies of advertisements from the AMA's national ad campaign and information about placing the ads in local newspapers to county societies that do not receive the information directly from AMA. The AMA campaign was launched last month and will extend over 35 weeks in 45 issues of six national publications. The ads will focus on the positive aspects of U.S. medicine, including: (1) Growing number and increasing capability of today's physicians; (2) Preventive health measures; (3) Emphasis on continuing medical education; and (4) AMA's role in cost containment.

### Risk Management

To help reduce the risk of malpractice suits, ISMS—in cooperation with the Illinois State Medical Inter-Insurance Exchange—will produce for distribution to members a series of pamphlets presenting professional liability case studies. The pamphlets—which will be mailed monthly—will summarize cases from actual claim files. This is one phase of a developing risk management program under the ISMS Task Force on Professional Liability.

## Health Care Institutions

ISMS will work with the Illinois Hospital Association and/or Chicago Hospital Council to explore the feasibility of a pilot study regarding the cost effectiveness of hospitals operating seven-days-per-week. Initial discussions will be aimed at identifying similar projects currently being conducted; the cost of initiating a new study; and how results would be utilized.

## State Fair Exhibit

ISMS will sponsor an exhibit at the Illinois State Fair this summer, with at least part of the exhibit devoted to the problem of alcoholism. This is part of an alcoholism education program supported by a grant from the Illinois Division of Alcoholism.

## Elections/Appointments

Sixth District Trustee Dr. Robert Hartman, Jacksonville, was elected Board chairman, succeeding Dr. Robert Fox, Chicago. Elected chairmen of Board committees were: Dr. Lawrence Hirsch, Chicago, Policy Committee; and Dr. Allan Goslin, Streator, Finance Committee.

A special ISMS Data Committee was appointed to evaluate the ISMS role in the Illinois Comprehensive Health Data System (ICHDS), focusing on the relationship of ISMS policies to the present ICHDS structure. Named to the committee were the 11 ISMS representatives currently serving on the ICHDS board plus one IFMC representative and one PSRO representative. Dr. Paul Peterson, IDPH director, also was named to the committee. ICHDS is designed to eliminate duplication of data collection efforts and maintain data gathering activities in the private sector rather than under government control.

## Council and Committee Changes

The Committee on Governmental Health Program Reimbursement was renamed as the Committee on Third Party Payment Processes, responsible for dealing with government and others relative to purchase of care. The move is designed to limit the scope of this special Board committee to situations requiring negotiations. The change also will eliminate an overlap in responsibility between the committee and the ISMS Council on Economics and Peer Review.

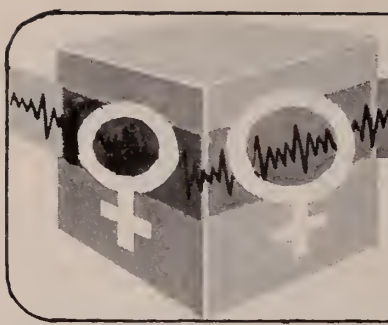
In related action, the Board will seek an amendment to the bylaws revising the "charge" to the Council on Economics and Peer Review to include: Ongoing relationships with third parties; fee review; health care costs and utilization; and quality of care review.

The Board also will seek a bylaws amendment expanding the "charge" of the Council on Affiliate Societies, thus allowing the Council to "initiate recommendations to the Board of Trustees on legislative matters affecting any specialty society." An invitation to appoint a representative to the Council will be extended to the Chicago Laryngological and Otologic Society.

## Panel For The Impaired Physician

The ISMS Auxiliary will develop a method of assisting spouses of impaired physicians while those physicians are utilizing services of the Panel for the Impaired Physician. A special Auxiliary committee will be formed, with the chairman serving as a member of the ISMS Panel.

Added to the ISMS Panel for the Impaired Physician were: Drs. Lynn Hankes, Aurora; John Oldershaw, Great Lakes; Deming Payne, Willowbrook; Michael Van Dyce Hinken, Rockford; Herbert Trace, Evanston; Sam Durr, Rock Island; Richard Banta, Rockford; Peter Talso, Chicago; and John Cronin, Oak Brook.



# *pulse...* of the ISMS auxiliary

Mrs. Eugene Vickery, Editor



## *Growth Patterns*

# *Our Next Fifty Years*

*"I pray that the American people get angry, because anger is the prelude to courage."* Eric Hoffer

Mrs. Earl V. Klaren, President, ISMSA

As we begin the second half-century of Auxiliary work, it is fitting to direct attention to our present activities, determine our strengths and weaknesses, and chart our course for the future.

Our children have been of major concern over the past year. What legacy are we leaving them? What will their world be like when we are no longer here? Will our daughters be able to remain at home with their children if they so desire, to nurture them as we were nurtured? Will they be allowed to have children, and if so, where will they be born? What manner of education will be theirs, and who will shape their values?

Many of these issues are being decided in our nation's Capitol without our input. If we are not totally involved at this time, some solutions will not be those we would have chosen.

If present trends are not reversed, what will happen to the family, the roots and life-line of a healthy, viable society? If two incomes are an economical necessity, will young parents have to resort to the use of federally-controlled Early Childhood Development Centers during working hours? What social, psychological, and health-related problems will a generation of these children produce?

What will our lives be like in the year 2000? Will the prudent investments of 1978 be adequate to provide for a comfortable retirement, or a bare subsistence?

If our pace slows and we are no longer "useful" by modern definition, will society tolerate us and our problems? Good question. . . .

At this moment, experts in some bureaucratic burrows are hatching far-out plans that just might concern you and me—plans to save the taxpayers a little money. That line of economic thinking became apparent in recent weeks when the powers-that-be generously granted our senior citizens an extra five years of taxpaying. Why? Because the social security funds are running

out sooner than had been expected. What benevolent bureaucratic scheme will be imposed to keep the nation solvent in the next decade should too many hearty souls survive this added "benefit"? These disturbing questions have not surfaced recently. They have been developing for the past fifty years.

Most of us in the medical community were introduced to the socio-political arena when our toes were trod upon. Most of us were drawn into the fray as one-issue individuals, but all issues are interrelated and *the bottom line is the dollar.* We cannot find a means to preserve the quality, confidentiality, and free choice in medicine without becoming involved politically.

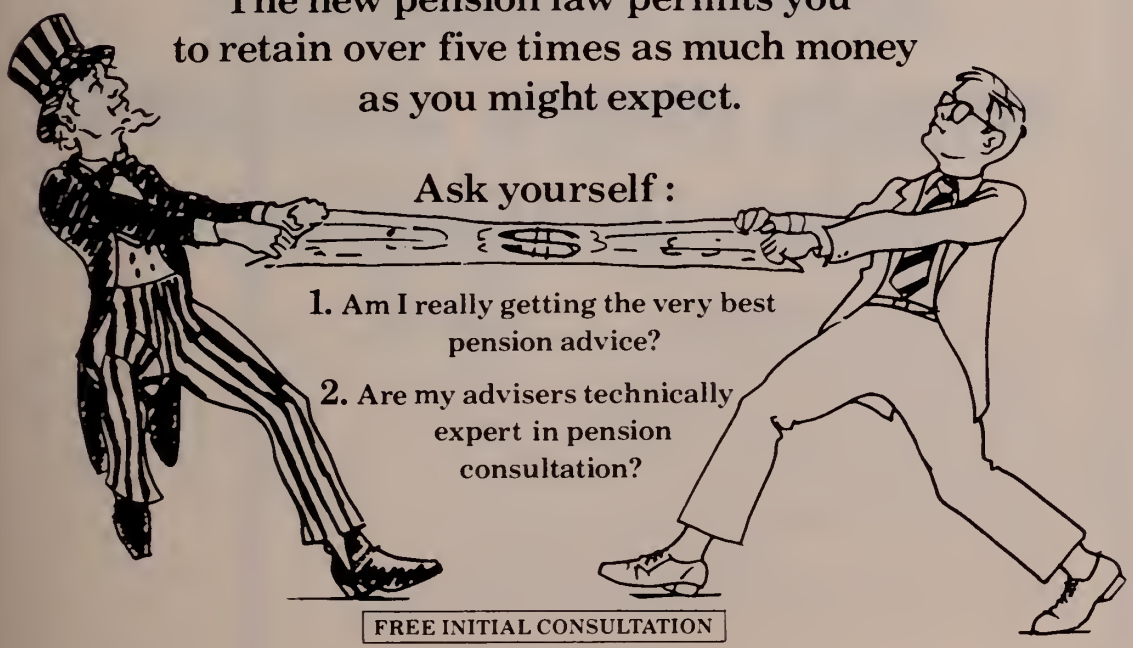
It occurs to me that my successor's year of tenure will end in 1980. Think of it: 1980. We are not ready for 1980; it has an ominous sound. Someone has said that 1984 came about 1935 only nobody noticed. Those were difficult times, and the common folk were scurrying for a living.

Could that be the situation today? Are most people too busy trying to maintain a recently-acquired affluence built on economic sand? Too busy to practicipate in the democratic process?

Eugene O'Neill's "Grandstand of Passive Observation" may be a comfortable place from which to view the passing scene in these troubled times, but the price of admission comes very high. One might say, "I won't be around to pay the price. Let the next generation do it." But the next generation is our own children.

Auxiliary can be used as a powerful tool to promote programs that will strengthen the family and protect it. The living conditions we found in this country were gifts freely given and made possible by the sacrifices of others who came before us.

True Auxiliary work is not just a hobby or time-filler. The results of some of our more successful projects may be the only legacy we can leave our children. As we begin a new year, let us pledge to go forward with a renewed sense of dedication and purpose with these thoughts in mind. ◄


FREE INITIAL CONSULTATION

American Society Pension Actuaries

Consultants to the Chicago Medical Society Employees Pension Plan

National Association Pension Consultants

Mann, Levine & Weiss, Ltd. 3525 W. Peterson, Chicago, IL 60659

(312) 539-7820 Pension Consultants and Plan Designers (312) 539-7820

## IMMEDIATE OCCUPANCY

# park west medical plaza

## An Original Concept

*A one story medical and dental building with private entrances for each suite and ample, adjacent parking. A landscaped environment emphasizing your identity and ease of access for patients.*

SUPERB LOCATION

- *Near downtown Highland Park.*
- *3 minutes from Highland Park Hospital.*
- *One block from Skokie Highway*

UNIQUE FEATURES

- *Individual thermostatic controls in all suites.*
- *Private Toilets*

OUTSTANDING ENVIRONMENT

- *A totally efficient and relaxed atmosphere.*
- *The outstanding medical building in the Chicago area.*

COMPLETE DESIGN FLEXIBILITY

- *Architect designed and built to suit you.*
- *Easy installation of any facilities within suites.*

For Leasing Information Contact:

**Milico Development Co. 5500 W. Touhy Avenue Skokie, Illinois 60076 (312) 674-7033**

# Army Medicine wants more doctors who specialize.

If you're a physician specializing in pediatrics, anesthesiology, radiology, or internal medicine, we've got a full range of career opportunities for you.

These opportunities are available in a setting that's about as free from non-medical distractions as it's possible for a practice to be. If you're a doctor who's more interested in practicing medicine than the running of a practice, Army Medicine could be perfect for you. Just call your local Army Medical Counselor, and he will discuss specific assignment opportunities with you.

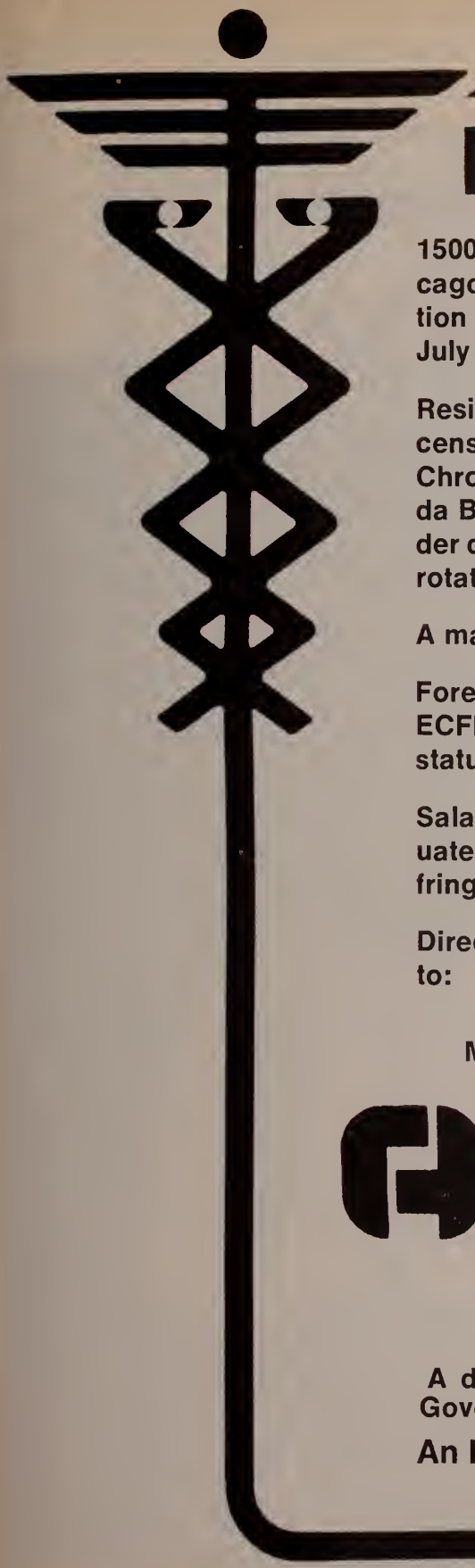
Counselor/Phone Number

Captain Alex Fedorov 312-926-2147

or

Captain George Warneck 314-268-3846

**Army Medicine. The practice that's practically all medicine.**



# RESIDENTS

1500 bed chronic disease hospital in Chicago suburbs with acute and rehabilitation services has openings available for July 1st, 1978.

Residencies approved by Illinois State Licensing Board for Geriatric Medicine and Chronic Diseases under direction of Dodda B. Rao, M.D. and Adult Cardiology under direction of Aldo A. Luisada, M.D. with rotation through services.

A major affiliate of two medical schools.

Foreign graduates must have VQE or ECFMG certificate and immigrant visa status.

Salary dependent on previous post-graduate training and experience. Excellent fringe benefits.

Direct all inquiries with curriculum vitae to:

JACK SOBEL, M.D., F.A.C.P.
Medical Director & Chief of Staff

## OAK FOREST HOSPITAL

15900 S. CICERO AVE.
OAK FOREST, ILL. 60452

A division of the Health and Hospitals Governing Commission of Cook County

An Equal Opportunity Employer M/F

# contains no aspirin

tablets

# Darvocet-N® 100 Ⓒ IV

100 mg. Darvon-N® (propoxyphene napsylate)
650 mg. acetaminophen

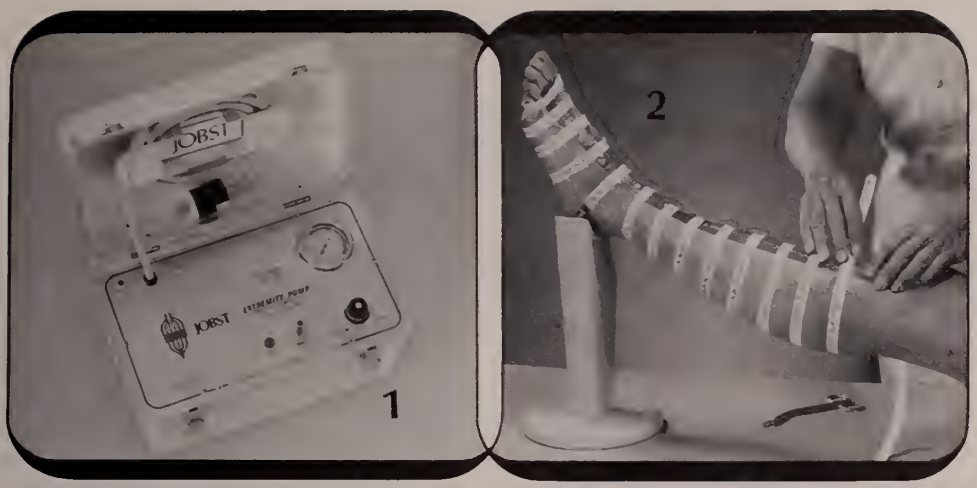



Lilly

*Additional information available to the profession on request from Eli Lilly and Company Indianapolis, Indiana 46206*

700565

Eli Lilly and Company, Inc.
Carolina, Puerto Rico 00630




# Twin Engineering Devices, to Reduce Massive Lymphedema, and Maintain the Reduction.

Massive and obstinate lymphedema of the limbs may be reduced through use of the Jobst Extremity Pumps (Intermittent Compression) (photo 1). Its controlled pneumatic massage gently removes edema fluid from congested areas.

Jobst Extremity Pumps are available in hospital, clinical, and home models (shown), the latter being available on rental. All units have controls to vary both pressure and time cycles.

When the desired reduction is attained, it can be maintained with a *Jobst Venous Pressure Gradient®* Support. These supports are custom-made to your prescription and the patient's individual measurements (photo 2). You may prescribe exact counterpressures. "In-Patient" orders will be given special attention.

**Contact your local Jobst Service Center for complete details.**

## JOBST CHICAGO SERVICE CENTER

**Chicago, Illinois 60602**
Suite 2101, Pittsfield Bldg.
55 E. Washington Street
312/346-0446

# Physician Recruitment Program

*In an effort to reduce the number of towns in Illinois needing physicians, the Physician Recruitment Program and the Doctor's Job Fair, are publishing synopses in the Journal.*

*Physicians who are seeking a place to practice or who know of any out-of-state physicians seeking an Illinois residence are asked to notify the Program.*

*Any areas wishing to be listed should contact: Mrs. E. Duffy, Physician Recruitment Program, ISMS, 55 E. Monroe, Suite 3510, Chicago, 60603.*

**BRAIDWOOD:** Physician for family practice, 20 miles south of Joliet—60 miles south of Chicago. No other doctor in town of 5,000. Next door to pharmacy. Clinic provided, substantial guaranteed income for 17 hours per week. One year contract. Contact: Ron Radley, Box 795, Braidwood 60408. (815) 458-2224 or (815) 634-4900. (6)

**CANTON:** Coleman Clinic, Ltd. Population 15,000; drawing area 60,000. Twelve physicians; multi-specialty clinic. Planning expansion program. Progressive city and clinic offering outstanding opportunity to primary care physician. Guaranteed salary and excellent benefits. Contact: H. E. Crouch, 175 S. Main St., Canton, 61520. (309) 647-0201. (6)

**CASEY:** Family physician. Practice quality rural medicine having advantage of group, but independence of solo practice. New complete facilities. Financial assistance available. This is the area to work, live, and enjoy families. Superb congenial doctors & colleagues to share your work. Before you decide, come see our operation. Contact: B. F. Vondracek, Casey Medical Center, Casey, 62420. (217) 932-4061. (6)

**CHADWICK:** Rural community in picturesque Northwestern Illinois, 125 miles west of Chicago. Need for a family physician in a solo practice or possible clinical association. Office space available. Contact: Harold Frank, 411 First St., Chadwick, 61014, (815) 684-5154 or 684-5147, Allen Smith, Rural Route, Chadwick, 61014, (815) 684-5200 or 684-5152. (6)

**CHICAGO:** Opportunities Available for Family Practitioners in a single specialty clinic setting. Association as a satellite facility with a 265 bed community hospital. Opportunity to build own practice with financial assistance available. Contact: Teryl R. Filebark, 1044 N. Francisco Ave., Chicago 60622. (312) 278-8800. (9)

**CHICAGO** (desirable suburb): Older general practitioner has excellent office facilities to share with younger G.P. Objective: need help with practice. Younger man may have guarantee to take over practice in near future. Hospital staff appointment available. All replies confidential. Box MK, Physician Recruitment Program, ISMS. (9)

**DeKALB:** Northern Illinois University. Physician for women's intercollegiate athletic teams and primary care practice in large university health service. Excellent facilities and working conditions, ideal community, good geographic location. Salary based on qualifications; Illinois license required. Start August 15 or earlier. Continuing 9 or 12 month contract. AA/EOE. L. W. Akers, M.D., Director, UHS, Northern Illinois University, DeKalb, Illinois 60115. (8)

**DOUGLAS COUNTY:** Population 20,000. Family practitioners needed in Villa Grove and Arcola. Twenty-five miles from Champaign and University of Illinois. 58 bed general acute hospital in Tuscola. Contact: J. Lindsey, Qualicare Inc., P.O. Box 24189, New Orleans, LA 70184, (504) 837-6456. (6)

**FAIRBURY:** Primary Care Physicians — Excellent practice opportunities in thriving rural community; enjoy life and your practice in an area which offers excellent facilities and a personal, friendly atmosphere; join the staff of 112-bed JCAH accredited community hospital. Write: Frank Brady, Administrator, Fairbury Hospital, Fairbury, IL 61739. (9)

**FAIRFIELD:** Population 6,000. Rural area with a service population of 25,000. Seventy miles from Evansville, Indiana. Opening in medical clinic for obstetrician-gynecologist, family practitioner, or internist interested in doing family practice. Financial assistance available. Contact: Dr. Arthur Marks or Dr. Sigmund Konarski, 101 E. Center Street, Fairfield, 62837. Telephone: (618) 842-2187. (6)

**FORT MADISON, IOWA:** Openings for 2-4 FP/GP, Ped., in growing industrial city of 16,000 serving 70,000 on Mississippi River. Solo, partnership, clinic available. Substantial salary, other incentive. U. of Ia. near, excellent living area, 125 bed accredited hospital. Contact Donald A. Buckert, Fort Madison Community Hospital, Fort Madison, Ia. 52627. (319) 372-6530. (7)

**FREEPORT:** Internist-general internist or internist with sub-specialty, board certified or eligible to join multi-specialty group in community of 35,000 in Northern Illinois. Excellent salary first year then partnership. Excellent retirement and fringe benefits. Send curriculum vita and references to K. H. Shons, Business Manager, Freeport Medical Clinic, Ltd., 3103 West Stephenson Road, Freeport, 61032. (815) 235-6131 (7)

**GALESBURG:** Excellent opportunities in ENT, Family Practice, Internal Medicine, Ob-Gyn. West-central Illinois community of 40,000, manufacturing & agricultural center. Home of Knox College. Outstanding educational, recreational, and cultural environment. Financial incentives and new medical office building available. Contact: Marshal G. Maggard, President, Galesburg Cottage Hospital, Galesburg, 61401. (309) 343-8131. (6)

**HERRIN:** Population 10,000. Trade area 40,000. Located in beautiful vacationland of Southern Illinois, near major university and medical school. Family Practice and OB-Gyn needed. Solo or clinic available. Excellent financial program provided. Modern well equipped hospital. Call collect or write, Larry Feil, Herrin Hospital, Herrin, 62948—Tel. (618) 942-4710. (7)

**ILLINOIS:** The Illinois Department of Mental Health and Developmental Disabilities has opportunities in all areas of the state for psychiatrists and primary care physicians. M.D.'s and D.O.'s with Illinois licenses will be considered. Competitive salaries commensurate with training and experience; attractive fringe benefits. Contact: John T. Nelson, M.D., Coordinator of Medical Affairs, 750 South State Street, Elgin, 60120. (312) 742-1040, x321. (6)

**JACKSONVILLE:** Opportunities for family practice, internal medicine, ENT, orthopedic surgery, emergency room. Progressive 250 bed hospital, 40 member medical staff. Prosperous community with service area of 60,000, two colleges, excellent schools, 30 miles from medical school. Financial assistance, office facilities available. Contact: Bernie Gregory, Passavant Hospital, Jacksonville 62650. (217) 245-9541. (6)

**LIBERTYVILLE:** Family practice physician, general practitioner, or internist to join outpatient clinic in rapidly growing area near lakes, shopping centers, recreation areas, and easy access to Chicago theaters, museums and cultural events. Clinic consists of full auxiliary facilities, special procedure rooms and future outpatient surgical center. For information contact: Family Medical Center, Rt. 1, Box 351, Libertyville 60048, (312) 362-9097. (6)

**MENDOTA:** General practice, second physician for Wholistic Health Center of Mendota, Illinois. Innovative program with additional staff for counseling and patient education. Excellent local hospital. Future openings available in five other Wholistic Health Centers in the planning stage. Call or write: Lucy Young, M.D., 607 Tenth Ave., Mendota, 61342. (815) 539-3888 (7)

**PEORIA:** Emergency physician—Unique opportunity to start on the ground floor with fee-for-service group in 550-bed medical center seeing 27,000 ER visits. Need career-minded physician for three 16-hour shifts per week with four weeks paid vacation. Compensation 57K with excellent corporate benefits plus incentive compensation. Flexible scheduling to allow individual pursuits in university town of 250,000 in Central Illinois. Contact: Hospital Emergency Physicians S.C., 221 Northeast Glen Oak, Peoria, 61636; phone 309-672-4974. (8)

**PRINCETON:** Family physician & internist—population 10,000, lovely community with excellent school and recreational facilities. Excellent hospital facility built in early 1970's. New office building attached to hospital will be completed in Spring of 1978. Specialties of internal medicine, OB, orthopedics, pediatrics, surgery, and urology available to complement the family physician. Contact: Harold L. Autrey, 530 Park Avenue East, Princeton 61356. (815) 875-2811. (6)

**SPRINGFIELD:** Family practitioners — Springfield Community Hospital is looking for you to begin private practice in our new multi-specialty Community Medical Plaza. We offer an attractive package to help you get started. If interested, contact: W. H. Fields, Springfield Community Hospital, 5230 S. 6th St., Springfield, 62703. (217) 529-7151. (6)

**UNION COUNTY:** Population 17,000. Clinic and office facilities available for family practitioner and physician of internal medicine. Special Care Unit under construction in County Hospital. Nearby cities of Carbondale and Cape Girardeau 25 miles away. Recreational facilities plentiful. Contact: E. A. Helfrich, 517 N. Main, Anna, 62906 AC 618-833-5155. (7)

**WAUKEGAN:** Population 67,000, northern Chicago Suburb. Newly remodeled medical center near hospital. Looking for Internist, Family Physician. Contact Washington Center, 1515 Washington St., Waukegan 60085, Y. Lee, M.D. 312-336-2221 or 729-5407. (9)


**Rush Medical College**
**Department of Family Practice**
**Invites You To**
**"Five Wednesdays with Family Practice"**

*Board Review and Clinical Update*
*June 28, July 5, 12, 19 and 26, 1978*

For registration information and copy of brochure, please write:

Harold A. Paul, M.D., M.P.H
Associate Dean
Office of Continuing Education
600 S. Paulina Street
Chicago, Illinois 60612

or telephone: (312) 942-6917

# Viewbox

*(Continued from page 352)*

DIAGNOSES: A. Normal Adrenal glands
B. Adrenal pseudocyst
C. Hemorrhagic pheochromocytoma

## *Discussion:*

The diagnostic efficacy of whole body computed tomography is now well documented. Several reports have already appeared in the radiographic literature emphasizing its usefulness in identifying retroperitoneal pathology related to kidneys,[1,2] pancreas,[3] and lymph nodes.[4]

Although CT scanning of the adrenals is still an emerging modality lacking the support of large series of cases, in our experience over 90% of normal size adrenal glands are easily demonstrated when a narrow beam width (5 to 10 mm), 0.5 to 1 cm. slice incrementation, and 5 to 10 seconds scan time (retrospective study of 60 cases) are utilized. Previous publications showed 88% visualization of the left adrenal and 66.6% of the right.[5]

Figure A demonstrates visualization of both normal adrenals, in the same scan cut. The ability to differentiate between cystic and solid lesions is demonstrated in Figure B, which shows a low density (water density) adrenal mass with CT numbers characteristic of water. This case of an adrenal pseudocyst was difficult to differentiate from an upper pole renal mass with drip infusion nephrotomography.

A solid but inhomogenous mass (lower central density) secondary to hemorrhage within the tumor is shown in Figure C, a case of left adrenal pheochromocytoma. A pitfall in diagnosis can occur in certain adrenal tumors with a high fat or cholesterol content[6] as is one of our cases of an aldosterone producing tumor of the adrenal cortex. Since ultrasonography of the adrenal glands has improved with the advent of grey scale, 85% successful visualization of normal adrenals has been obtained with improved transducers and special scanning techniques in a recent publication.[7] In our experience the technique is difficult to duplicate, each adrenal gland is imaged separately, the display of adjacent structures (organ extension) is restricted, and visualization is limited in obese patients. The original isotopic agent for radionuclide adrenal imaging was iodine 131-19-iodocholesterol which had significant radiation dosimetry to the gonads. It has recently been replaced with iodine 131-NP-59, which has a greater concentration in the adrenal glands with markedly decreased contribution to gonadal irradiation.

Radionuclide scanning is primarly indicated at the present time for suspected aldosteronoma and to a lesser degree for other functional diseases of the adrenal cortex. It provides less meaningful information on the medulla and non-functional diseases of the gland.

In the search for recurrent functional tumors, residual functional adrenal tissue, as well as transplanted adrenal tissue, radionuclide scanning might become the procedure of choice.

It is the hoped that the judicious use of these non-invasive imaging procedures will make invasive techniques such as arteriography and venography less necessary in the work-up of adrenal diseases, and that in specific cases surgical planning can be decided without their use.

### References


1. Sagel, S. S., Stanley, R. J., Levitt, R. G., and Geisse, G.: "Computed Tomography of the Kidney," *Radiology* 124:359-370, August, 1977.
2. Schaner, E. G., Balow, J. E. and Doppman, J. L.: "Computed Tomography in the Diagnosis of Subcapsular and Perirenal Hematoma," *Am. J. Roentgenol.*, 129:83-88, July, 1977.
3. Sheedy II, P. F., Stephens, D. H., Hattery, R. R., MacCarty, R. L. and Williamson, B.: "Computed Tomography of the Pancreas," *Radiol. Clin. North Am.*, 15: 349-366, 1977.
4. Harrel, G. S., Breiman, R. S., Glatstein, E. J., Marshall, W. H. and Castellino, R. A.: "Computed Tomography of the Abdomen in the Malignant Lymphomas," *Radiol. Clin. North Am.*, 15:391-400, 1977.
5. Brownlie, K. and Kreel, L.: "Computer Assisted Tomography of the Normal Suprarenal Glands," *J. Comput. Assist Tomogr.*, 2:1-10, 1978.
6. Schaner, E. G., Dunnick, N. R., Doppman, J. L., Strott, C. A., Gill, J. R. and Jauadpour, N.: "Adrenal Cortical Tumors with Low Attenuation Coefficients: A Pitfall in Computed Tomography Diagnosis," *J. Comput. Assist. Tomogr.*, 2:11-15, 1978.
7. Sample, W. F.: "A New Technique for the Evaluation of the Adrenal Gland with Gray Scale Ultrasonography," *Radiology*, 124:463-469, August, 1977.

# A Difference in Theophylline Therapy

## micro-pulverized BRONKODYL® Capsules

brand of theophylline, USP anhydrous




- Blood levels as fast as an elixir
- With minimal gastric irritation*

*Please see complete prescribing information, a summary of which follows.

SCRIPTION:
ch green and white hard gelatin capsule contains theophylline USP anhy-
ous, 200 mg., in a micro-pulverized form. Each brown and white hard gelatin
sule contains 100 mg. The elixir contains 80 mg. theophylline per 15 ml.
a 20% alcohol elixir (approximately 20 calories, 0.9 gm carbohydrate per
lespoonful).

TION: Theophylline is a methylxanthine which relaxes the smooth muscu-
ure of the bronchioles through its inhibition of the conversion of cyclic
enosine monophosphate to adenosine monophosphate by phosphodiester-
e. It also has diuretic, cardiotonic, and CNS stimulant effects.

DICATIONS: Bronkodyl is indicated for symptomatic relaxation of bronchiolar
sm in the chronic obstructive bronchopulmonary diseases; e.g., bronchial
hma, chronic bronchitis and pulmonary emphysema.

NTRAINDICATIONS: Bronkodyl Is contraindicated in persons known to
ve had serious idiosyncratic responses to theophylline, its salts, or the other
thylxanthines, theobromine, or caffeine and may be contraindicated in peptic
er.

RNINGS: All methylxanthines should be used with caution in children and in
ers who are currently taking bronchodilator products, especially in rectal
sage form, which may contain theophylline or related drugs.

AGE IN PREGNANCY: Although theophylline has been used for many
ars. with no evidence of adverse fetal effect or teratogenicity, its safety in
gnancy has not been established. Therefore use of Bronkodyl during lacta-
n or in women of childbearing potential requires that possible benefits of the
g be weighed against possible hazards to fetus or child

ECAUTIONS: Bronkodyl should be used with caution in patients with cardiac
circulatory disease.

ADVERSE REACTIONS: Gastrointestinal: Epigastric distress, nausea, vomiting. Cardiovascular: palpitations. CNS: Insomnia, restlessness, irritability, convulsion.

DOSAGE AND ADMINISTRATION: Adults: Usual dosage of Bronkodyl is 200 mg. every 6 hours (four doses in each 24 hours). This dosage may be adjusted to reflect individual clinical response as an indication of slow or rapid metabolism of the drug. If adverse reactions are encountered, each dose may be reduced, or the interval between doses may be lengthened, or both. If clinical response is not satisfactory, indicating possible rapid inactivation of the drug, dosage may be gradually increased to achieve the desired response. In some instances of either too slow or too rapid metabolism, plasma levels of theophylline should be determined and dosage adjusted accordingly to achieve levels above 10 mcg/ml, but not to exceed 20 mcg/ml.

Dosage in Children: Usual dosage should be based on administration of 10 mg per kg per 24 hours, divided in 4 doses per day, given every 6 hours. As this may not be possible with use of the capsules, Bronkodyl elixir may be used. Theophylline saliva levels (approximately 60% of simultaneous blood levels), may facilitate dosage adjustments, especially in children, to obtain appropriate response.

HOW SUPPLIED:
Bronkodyl 100 mg., brown and white capsules in 100's, Code #1831.
Bronkodyl 200 mg., green and white capsules in 100's, Code #1833.
Bronkodyl Elixir, 80 mg. per 15 ml, in pints, Code #1835.

BREON

BREON LABORATORIES INC.
90 Park Avenue, New York, N.Y. 10016




# IN THE ILLINOIS AREA, STAPH RESISTANCE HAS NOW REACHED 79%.*

*resistance to penicillin G among community-acquired staph infections. Data on file, Bristol Laboratories.

## WHEN YOU CAN'T RULE OUT STAPH, CONSIDER

# TEGOPEN®

# (cloxacillin sodium)

## ..."THE PENICILLIN OF TODAY"

- Effective against nonpenicillinase-producing staphylococci, beta-hemolytic streptococci, and pneumococci.†

†NOTE: The choice of Tegopen should take into consideration the fact that it has been shown to be effective only in the treatment of infections caused by pneumococci, Group A beta-hemolytic streptococci, and penicillin G-resistant and penicillin G-sensitive staphylococci. If the bacteriology report later indicates that the infection is due to an organism other than a penicillin G-resistant staphylococcus sensitive to cloxacillin sodium, the physician is advised to continue therapy with a drug other than cloxacillin sodium or any other penicillinase-resistant semisynthetic penicillin. The clinical significance of *in vitro* data is unknown.

- 10 times more active against strep than staph.

- Well absorbed from the G.I. tract.‡

‡Maximum absorption occurs when Tegopen is taken on an empty stomach, preferably 1-2 hrs. before meals.



**Please see brief summary for prescribing information.**

**Brief Summary of Prescribing Information**
**Combined TEGOPEN® (cloxacillin sodium)**
**Capsules and Oral Solution**
For complete information, consult Official Package Circular. (12) TEGOPEN 9/11/75

**Indications:** Although the principal indication for cloxacillin sodium is in the treatment of infections due to penicillinase-producing staphylococci, it may be used to initiate therapy in such patients in whom a staphylococcal infection is suspected. (See Important Note below.)

Bacteriologic studies to determine the causative organisms and their sensitivity to cloxacillin sodium should be performed.

**Important Note:** When it is judged necessary that treatment be initiated before definitive culture and sensitivity results are known, the choice of cloxacillin sodium should take into consideration the fact that it has been shown to be effective only in the treatment of infections caused by pneumococci, Group A beta-hemolytic streptococci, and penicillin G-resistant and penicillin G-sensitive staphylococci. If the bacteriology report later indicates the infection is due to an organism other than a penicillin G-resistant staphylococcus sensitive to cloxacillin sodium, the physician is advised to continue therapy with a drug other than cloxacillin sodium or any other penicillinase-resistant semi-synthetic penicillin.

Recent studies have reported that the percentage of staphylococcal isolates resistant to penicillin G outside the hospital is increasing, approximating the high percentage of resistant staphylococcal isolates found in the hospital. For this reason, it is recommended that a penicillinase-resistant penicillin be used as initial therapy for any suspected staphylococcal infection until culture and sensitivity results are known.

Cloxacillin sodium is a compound that acts through a mechanism similar to that of methicillin against penicillin G-resistant staphylococci. Strains of staphylococci resistant to methicillin have existed in nature and it is known that the number of these strains reported has been increasing. Such strains of staphylococci have been capable of producing serious disease, in some instances resulting in fatality. Because of this, there is concern that widespread use of the penicillinase-resistant penicillins may result in the appearance of an increasing number of staphylococcal strains which are resistant to these penicillins.

Methicillin-resistant strains are almost always resistant to all other penicillinase-resistant penicillins (cross-resistance with cephalosporin derivatives also occurs frequently). Resistance to any penicillinase-resistant penicillin should be interpreted as evidence of clinical resistance to all, in spite of the fact that minor variations in *in vitro* sensitivity may be encountered when more than one penicillinase-resistant penicillin is tested against the same strain of staphylococcus.

**Contraindications:** A history of a previous hypersensitivity reaction to any of the penicillins is a contraindication.

**Warning:** Serious and occasionally fatal hypersensitivity (anaphylactoid) reactions have been reported in patients on penicillin therapy. Although anaphylaxis is more frequent following parenteral therapy it has occurred in patients on oral penicillins. These reactions are more apt to occur in individuals with a history of sensitivity to multiple allergens.

There have been well documented reports of individuals with a history of penicillin hypersensitivity reactions who have experienced severe hypersensitivity reactions when treated with a cephalosporin. Before therapy with a penicillin, careful inquiry should be made concerning previous hypersensitivity reactions to penicillins, cephalosporins, and other allergens. If an allergic reaction occurs, the drug should be discontinued and the patient treated with the usual agents, e.g., pressor amines, antihistamines, and corticosteroids.

Safety for use in pregnancy has not been established.

**Precautions:** The possibility of the occurrence of superinfections with mycotic organisms or other pathogens should be kept in mind when using this compound, as with other antibiotics. If superinfection occurs during therapy, appropriate measures should be taken.

As with any potent drug, periodic assessment of organ system function, including renal, hepatic, and hematopoietic, should be made during long-term therapy.

**Adverse Reactions:** Gastrointestinal disturbances, such as nausea, epigastric discomfort, flatulence, and loose stools, have been noted by some patients. Mildly elevated SGOT levels (less than 100 units) have been reported in a few patients for whom pretherapeutic determinations were not made. Skin rashes and allergic symptoms, including wheezing and sneezing, have occasionally been encountered. Eosinophilia, with or without overt allergic manifestations, has been noted in some patients during therapy.

**Usual Dosage:** Adults: 250 mg. q.6h.

Children: 50 mg./Kg./day in equally divided doses q.6h. Children weighing more than 20 Kg. should be given the adult dose. Administer on empty stomach for maximum absorption.

*N.B.:* INFECTIONS CAUSED BY GROUP A BETA-HEMOLYTIC STREPTOCOCCI SHOULD BE TREATED FOR AT LEAST 10 DAYS TO HELP PREVENT THE OCCURRENCE OF ACUTE RHEUMATIC FEVER OR ACUTE GLOMERULONEPHRITIS.

**Supplied:** Capsules—250 mg. in bottles of 100, 500 mg. in bottles of 100. Oral Solution—125 mg./5 ml. in 100 ml. and 200 ml. bottles.

BRISTOL®
BRISTOL LABORATORIES
Division of Bristol-Myers Company
Syracuse, New York 13201

# EKG

*(Continued from page 357)*

**Answers: 1. C.D. 2. E.**

The ECG shows atrial tachycardia with 2:1 AV block and ST-T waves compatible with digitalis effect. The QRS axis is normal at +60° and the atrial rate at 200 beats per minute is too slow for atrial flutter. (Note the P waves in lead $V_1$.) No voltage criteria for left ventricular hypertrophy are present. In view of the marked obesity of this patient and the presence of normal QRS voltage when it should be low, left ventricular hypertrophy might be suspected. In our patient, no cause for left ventricular hypertrophy was found.

Atrial tachycardia with AV block is a common arrhythmia in digitalis intoxication. This was suspected here and digitalis was discontinued. However, the arrhythmia persisted and no other manifestations of digitalis excess were seen. It was concluded that the arrhythmia was related to her calcific pericarditis. Although atrial tachycardia is seen in constrictive pericarditis, atrial fibrillation is the commonest arrhythmia. Subsequently, cardiac catheterization confirmed equalization of high filling pressures in the atrial and the ventricles compatible with constrictive pericarditis. Calcium in the pericardium is a clue to the diagnosis and may be present in 50 to 70 percent of cases. Our patient required surgical removal of the pericardium and did well despite her obesity.

For further reading on this topic see *Pericardial Diseases*, D. H. Spodik, ed., and *Cardiovascular Clinics*, F. A. Davis, Philadelphia, 1976 and C. A. Bush *et al.*,: "Occult Constrictive Pericardial Disease," *Circulation* 56:924, 1977.

# ISMS Guide to Continuing Medical Education

Compiled for Illinois physicians by the
ILLINOIS COUNCIL ON CONTINUING MEDICAL EDUCATION
55 E. Monroe St., Suite 3510 • Chicago, IL 60603 • (312) 236-6110

*Items for this Calendar must be received 90 days prior to the event. Those received earlier may appear in up to three monthly issues.*

*WARNING! Items for this Calendar come from many sources, often far in advance of the publication date. Sometimes, cancellations or changes in date, place or time occur too late to be corrected before publication. You are urged to contact the sponsoring organization to confirm information given below.*

## JUNE

### *Cardiology*

**ANNUAL REVIEW OF CARDIOLOGY FOR THE INTERNIST**
**For:** Cardiologists. Two-day lecture, June 8-9, 9:00 a.m., Chicago, Illinois. **Speaker:** Kenneth Rosen, M.D. **CME credit:** 30 hours, AMA category 1. **Fee:** $225. **Sponsor:** Cook County Graduate School of Medicine, 707 South Wood Street, Chicago, Illinois 60612. **Contact:** Robert J. Baker, M.D., Dean. **Telephone:** 312-733-2800.

### *Chest Diseases*

**HYPERSENSITIVITY LUNG DISEASE**
**For:** Physicians, nurses, therapists. Three-day postgraduate course, June 21-23, The Playboy Resort, Lake Geneva, Wisconsin. **CME credit:** 17 hours, AMA category 1. **Fee:** ACCP members, $160; Nonmembers, $185; Residents, nurses, therapists, $125. **Sponsor:** The American College of Chest Physicians, 911 Busse Highway, Park Ridge, Illinois 60068. **Co-sponsor:** Medical College of Wisconsin. **Contact:** Dale E. Braddy, Director of Education. **Telephone:** 312-698-2200.

### *Cost Containment in Medical Care*

**COST CONTAINMENT IN MEDICAL CARE**
**For:** All physicians. Panel discussion, June 21, 7:30 PM, Elmhurst Country Club, Wood Dale, IL. **Speaker:** J. M. Ingalls, M.D., Past President, ISMS. **CME Credit:** AMA Category 1: 2 hours. **Fee:** none. **Sponsor:** DuPage County Medical Society, 26 W. St. Charles, Lombard, IL 60148. **Contact:** Lillian S. Widmer, Executive Secretary. **Phone:** 312-495-4050.

### *Family Medicine*

**CEREBRAL VASCULAR INSUFFICIENCY**
**For:** Physicians. Lecture, June 20, 1978; 7:30 PM. Assembly Hall, Sherman Hospital, 934 Center Street, Elgin, Illinois. **Speaker:** Hushang Javid, M.D., Professor of Surgery, Rush Medical College. **Hrs. of Inst.:** 2. **CME Credit:** AMA Category 1. **Fee:** None. **Sponsor:** CME Committee, Sherman Hospital, 934 Center St., Elgin, IL. **Contact:** Mary Anne Stiegemeier, Secretary, CME Committee. **Telephone:** (312) 742-9800.

### *Flexible Bronchoscopy/Chest Diseases*

**PANORAMIC VIEW OF FLEXIBLE BRONCHOSCOPY TODAY**
**For:** Physicians, nurses, therapists. 2-day post graduate course, June 8-9, Continental Plaza Hotel, Chicago. **Speaker:** L. Penfield Faber, M.D., F.C.C.P. **CME Credit:** AMA Category 1: 13¼ hours. **Fee:** ACCP members, $150; non-member physicians, $175; residents, nurses, therapists, $100. **Sponsor:** American College of Chest Physicians, 911 Busse Hwy., Park Ridge, IL 60068. **Co-Sponsor:** Rush-Presbyterian-St. Luke's Medical Center. **Contact:** Mary Ellen Zielinski. **Phone:** 312-625-6064.

### *Internal Medicine & Surgery*

**FLUIDS & ELECTROLYTES**
**For:** Internists and Surgeons. Three-day lecture, June 15-17, 9:00 a.m., Chicago, Illinois. **Speaker:** Robert J. Baker, M.D. **CME credit:** 24 hours, AMA category 1. **Fee:** $175. **Sponsor:** Cook County Graduate School of Medicine, 707 South Wood Street, Chicago, Illinois 60612. **Contact:** Robert J. Baker, M.D., Dean. **Telephone:** 312-733-2800.

### *Medicine*

**RECENT ADVANCES IN INFECTIOUS DISEASES**
**For:** Physicians. Lecture, June 14, 1978. 950 East 59th St., Chicago, IL. **Hrs. of Inst.:** 6. **CME Credit:** AAFP Elective and AMA Category 1. **Fee:** $30.00. **Sponsor:** The University of Chicago, Frontiers of Medicine, 950 East 59th St., Chicago, IL. **Contact:** Elaine Ehrman, Secretary. **Telephone:** (312) 947-5777.

### *Medicine/Surgery*

**TWENTIETH MEDICAL SURGICAL SEMINAR FOR LAKE COUNTY**
**For:** Physicians, et al. Seminar, June 21, 1978. Mother Leonarda Hall, St. Therese Hospital, Waukegan, IL. **Hrs. of Inst.:** 5. **CME Credit:** AAFP Elective, AMA Category 1 and AOA. **Fee:** None. **Reg. Deadline:** June 20, 1978. **Sponsor:** St. Therese Hospital, 2615 Washington, Waukegan, IL. **Contact:** R. M. Adelman, D.D.S., M.D., Vice President—Medical Affairs. **Telephone:** (312) 688-5800.

### *Medicine*

**DIABETES UPDATE**
**For:** All physicians. 1-day symposium, June 20, Vandalia, IL. **CME Credit:** AAFP elective, 3 hours; AMA Category 1, 3 hours. **Fee:** none. **Sponsor:** Southern Illinois University School of Medicine, P. O. Box 3926, Springfield, IL 62708. **Contact:** Lorraine Stephenson, Registrar. **Phone:** 217-782-7711.

### *Ophthalmology*

**For:** Ophthalmologists. Weekly clinical conference, meeting Wednesdays, 4:00-6:00 PM, University of Illinois Eye & Ear Infirmary, Chicago, IL. **CME credit:** AMA Category 1, 2 hours. **Fee:** none. **Sponsor:** Department of Ophthalmology, University of Illinois Eye & Ear Infirmary, 1855 W. Taylor, Chicago, IL 60612. **Contact:** Carmen Carrasco. Secretary, Continuing Education Dept. **Phone:** 312-996-8023.

### *Pediatric Neurosurgery*

**SECOND ANNUAL POST-GRADUATE COURSE IN PEDIATRIC NEUROSURGERY**
**For:** Pediatric Neurosurgeons. 5-day conference, June 27-July 1, 1978. Alumni Center for Continuing Education, 301 East Chicago Ave., Chicago, IL **Hrs. of Inst.:** 35. **CME Credit:** AMA Category 1. **Fee:** $315.00. **Sponsor:** Northwestern University Medical School, Alumni Center for Continuing Education. **Contact:** James E. Dyson, Ph.D., Director, Continuing Education. **Telephone:** (312) 649-8533.

### *Psychiatry*

**OFFICE PSYCHIATRY**
**For:** All physicians. Symposium, June 3, Robinson, IL. **CME Credit:** AAFP elective, 4 hours; AMA Category 1, 4 hours. **Fee:** none. **Sponsor:** Southern Illinois University School of Medicine, P. O. Box 3926, Springfield, IL 62708. **Contact:** Lorraine Stephenson, Registrar. **Phone:** 217-782-7711.

### *Surgery*

**SURGERY**
**For:** All physicians. Symposium, June 15, Chester, IL. **CME Credit:** AAFP elective, 4 hours; AMA Category 1, 4 hours. **Fee:** none. **Sponsor:** Southern Illinois University School of Medicine, P. O. Box 3926, Springfield, IL 62708. **Contact:** Lorraine Stephenson, Registrar. **Phone:** 217-782-7711.

### *Surgery*

**MANAGEMENT OF COMMON SURGICAL PROBLEMS**
**For:** Surgeons. Conference, June 15-16, 1978. Chicago, IL. **Hrs. of Inst.:** 12. **CME Credit:** AMA Category 1. **Fee:** $125.00. **Reg. Limit:** 250. **Sponsor:** Northwestern University Medical School, Center for Continuing Education, 301 East Chicago Ave., Chicago, IL. **Contact:** James E. Dyson, Ph.D., Director of Continuing Education. **Telephone:** (312) 649-8533.

### *Surgery & Oncology*

**CURRENT CONCEPTS IN MANAGEMENT OF COMMON NEOPLASMS**
**For:** Surgeons and Oncologists. Three-day lecture, June 12-14, 8:00 a.m., Chicago, Illinois. **Speaker:** Tapas K. Das Gupta, M.D. **CME credit:** 24 hours, AMA category 1. **Fee:** $175. **Sponsor:** Cook County Graduate School of Medicine, 707 South Wood Street, Chicago, Illinois 60612. **Contact:** Robert J. Baker, M.D., Dean. **Telephone:** 312-733-2800.

### *Teaching*

**INSTRUCTIONAL ALTERNATIVES FOR HEALTH PROFESSIONS EDUCATION**
**For:** Health professions education faculty. Workshop. June 19-22, Sheraton Plaza Hotel, Chicago. **CME Credit:** AMA Category 2, 15 hours. **Reg. limit:** 80. **Fee:** $250. **Reg. deadline:** June 5. **Speaker:** George E. Miller, M.D. **Sponsor:** Center for Educational Development, University of Illinois at the Medical Center, 1853 W. Polk St., Room 144D, Chicago, IL 60612. **Contact:** Sue Korienek, Program Coordinator. **Phone:** 312-996-8025.

**TWO NEW PUBLICATIONS AVAILABLE FROM ICCME**

**SETTING DIRECTIONS IN CME** offers suggestions on how to develop goals and formulate learning objectives.

**CME PLANNING CHECKLISTS** offers steps in CME planning to help assure learner achievement of goals and objectives and offers model forms.

Illinois physicians may obtain a FREE copy by writing the title on their prescription blank and mailing it to ICCME.

**RECENT CME ACCREDITATION**
The ISMS Committee on CME Accreditation has recently approved the CME program of the following institution:

Northwest Hospital
Chicago

## JULY

*Family Medicine*

**SPECIALTY REVIEW FOR FAMILY PRACTICE**
**For:** Family Practitioners. 11-day lecture, beginning July 17, 8:30 a.m., Chicago, Illinois. **Speaker:** Harry Marchmont Robinson, M.D. **CME credit:** AAFP Elective, 98 hours; AMA category 1, 98 hours. **Fee:** $400. **Reg. limit:** 200. **Sponsor:** Cook County School of Medicine, 707 South Wood Street, Chicago, Illinois 60612. **Contact:** Robert J. Baker, M.D., Dean. **Telephone:** 312-733-2800.

*General Medicine*

**ADULT RESPIRATORY DISTRESS SYNDROME**
**For:** M.D.'s. Lecture, July 11, 5:00 PM, Henrotin Hospital Board Room, Chicago. **Speaker:** Manzoor Shah, M.D., Director of Respiratory Services. **CME credit:** AMA Category 1, 1 hour. **Fee:** none. **Sponsor:** Henrotin Hospital, 111 West Oak Street, Chicago, IL 60610. **Contact:** William N. Werner, M.D., Associate Director of Med. Education. **Phone:** 312-440-7753.

*Medicine*

**SPECIALTY REVIEW COURSE IN INTERNAL MEDICINE/CERTIFYING (PREP. FOR BOARD)**
**For:** Internists. 6½ day lecture, beginning July 30 & August 6, 1:00 p.m., Chicago, Illinois. **Speaker:** Sheldon S. Waldstein, M.D. **CME credit:** AMA Category 1, 64 hours. **Fee:** $275. **Reg. limit:** 600. **Sponsor:** Cook County Graduate School of Medicine, 707 South Wood Street, Chicago, Illinois 60612. **Contact:** Robert J. Baker, M.D., Dean. **Telephone:** 312-733-2800.

*Pediatrics*

**SPECIALTY REVIEW IN PEDIATRICS**
**For:** Pediatricians. 5½ day lecture, July 10-15, 8:30 a.m., Chicago, Illinois. **Speaker:** Ira DuBrow, M.D. **CME credit:** 44 hours, AMA catgeory 1. **Fee:** $250. **Reg. limit:** 200. **Sponsor:** Cook County Graduate School of Medicine, 707 South Wood Street, Chicago, Illinois 60612. **Contact:** Robert J. Baker, M.D., Dean **Telephone:** 312-733-2800.

*Radiology*

**RADIATION SAFETY & DIAGNOSTIC RADIOLOGY**
**For:** Radiologists. 3-day lecture, July 24-26, 8:00 a.m., Chicago, Illinois. **Speaker:** Theodore Fields, M.S. **CME credit:** 24 hours, AMA category 1. **Fee:** $175. **Reg. limit:** 75. **Sponsor:** Cook County Graduate School of Medicine, 707 South Wood Street, Chicago, Illinois 60612. **Contact:** Robert J. Baker, M.D., Dean. **Telephone:** 312-733-2800.

*Surgery*

**ADVANCED PERIPHERAL VASCULAR SURGERY**
**For:** Peripheral Vascular Surgeons 5-day lecture, July 17-21, 9:00 a.m., Chicago, Illinois. **Speaker:** Robert J. Baker, M.D. **CME credit:** AAFP elective, 40 hours; AMA category 1, 40 hours. **Fee:** $225. **Reg. limit:** 50. **Sponsor:** Cook County Graduate School of Medicine, 707 South Wood Street, Chicago, Illinois 60612. **Contact:** Robert J. Baker, M.D., Dean. **Telephone:** 312-733-2800.

*Surgery*

**FIBEROPTIC COLONOSCOPY**
**For:** Surgeons, Internists & Family Practitioners. 3-day lecture, July 12-14, 9:00 a.m., Chicago, Illinois. **Speaker:** Herand Abcarian, M.D. **CME credit:** AAFP elective, 19 hours; AMA category 1, 19 hours. **Fee:** $300. **Reg. limit:** 15, **Sponsor:** Cook County Graduate School of Medicine, 707 South Wood Street, Chicago, Illinois 60612. **Contact:** Robert J. Baker, M.D., Dean. **Telephone:** 312-733-2800.

*Surgery*

**FIBEROPTIC ESOPHAGOGASTRIC ENDOSCOPY**
**For:** Surgeons & Internists. 3-day lecture, July 12-14, 9:00 a.m., Chicago, Illinois. **Speaker:** C. Thomas Bombeck, M.D. **CME credit:** AAFP elective, 19½ hours; AMA category 1, 19½ hours. **Fee:** $300. **Reg. limit:** 15. **Sponsor:** Cook County Graduate School of Medicine, 707 South Wood Street, Chicago, Illinois 60612. **Contact:** Robert J. Baker, M.D., Dean. **Telephone:** 312-733-2800.

### *ATTENTION: CME PLANNERS*

**ICCME can help you build a high-quality CME program, worthy of accreditation, to help your colleagues satisfy the new Illinois Mandatory CME Law.**

**ICCME offers:**

- ***How to Start a CME Program*** **and other publications**
- **Informal consultation by our staff**
- **The "Workshop on CME Leadership" for leaders of hospital medical staffs and medical societies**
- **The Illinois Hospital CME Consultation Service**
- **Take advantage of *your* State Society's *unique* Council. For information, write or call:**

**Illinois Council/CME**
**55 E. Monroe, Suite 3510**
**Chicago, IL 60603**
**(312) 236-6110**

### *Challenge for CME Planners*

**Since Paul Sanazaro's "Medical Audit, Continuing Medical Education and Quality Assurance" appeared last September (*Western J Med*)—it has stimulated a new national debate on CME. One of his remarks: "CME does less than commonly believed to improve care." (He also points to ways of combining CME with medical audit to improve *both* CME and patient care.)**

**ICCME has just obtained permission to reproduce copies for Illinois physicians and CME sponsors. Any CME Committee will find this paper a stimulating *self-learning* experience—used as the text for a discussion session or two. If you and your colleagues can't resolve to your own satisfaction the issues Sanazaro raises—take that as evidence of the need to re-think goals, objectives, methods, and evaluation procedures presently used.**

**For FREE copies of the Sanazaro paper, just write "SANAZARO, Box J" on your prescription form and mail to:**

**Box J**
**Illinois Council on CME**
**55 E. Monroe St.**
**Chicago, IL 60603**

### *Cancer—Educational Materials*

**A variety of reprints, motion pictures (8mm and 16mm), tapes, slides, and exhibits are available from the American Cancer Society's Illinois office. That agency also maintains a speakers bureau. Topics covered include both physiological and psychological aspects; material is available to meet the needs of physicians, nurses, and patients.**

**For full information, write to . . .**
**Illinois Division, Inc.**
**American Cancer Society**
**37 South Wabash Avenue**
**Chicago, IL 60603**

## *AUGUST*

*Emergency Medicine*

**SEVENTH ANNUAL TRAUMA CRITICAL CARE SYMPOSIUM**
**For:** All emergency medical personnel. Lecture/technique sessions, Chicago, IL. **Beginning dates:** 8/31, 9/1. **Fee:** $70. **Reg. limit:** 800. **Sponsor:** Illinois Department of Public Health Services, Division of Emergency Medical Services, 160 North LaSalle, Chicago, IL 60601. **Co-Sponsors:** American Trauma Society, Illinois Chapter; Emergency Department Nurses Association, Illinois Chapter. **Contact:** Penny Finn, Coordinator, 525 West Jefferson, Springfield IL 62761. **Phone:** 217-785-2080.

*Internal Medicine*

**STATE & NATIONAL BOARD REVIEW, BASIC**
**For:** Internists. 6½ day lecture, August 6-12, Chicago, IL. **Speaker:** Sheldon S. Waldstein, M.D. **CME Credit:** AAFP Prescribed, 58 hours; AMA Category 1, 58 hours. **Fee:** $275. **Reg. limit:** 150. **Sponsor:** Cook County Graduate School of Medicine, 707 South Wood Street, Chicago, IL 60612. **Contact:** Robert J. Baker, M.D., Dean. **Phone:** 312-733-2800.

*Internal Medicine*

**STATE & NATIONAL BOARD REVIEW, CLINICAL**
**For:** Internists, family practitioners. Lecture, August 14-19, Chicago, IL. **Speaker:** Sheldon S. Waldstein, M.D., **CME credit:** AAFP Prescribed, 53 hours; **AMA** Category 1, 53 hours. **Fee:** $250. **Reg. limit:** 150. **Sponsor:** Cook County Graduate School of Medicine, 707 South Wood Street, Chicago, IL 60612. **Contact:** Robert J. Baker, M.D., Dean. **Phone:** 312-733-2800.

*Orthopaedics*

**SPECIALTY REVIEW IN ORTHOPAEDICS**
**For:** Orthopaedists. 7 day lecture, August 13-19, Chicago, IL. **Speaker:** Peter C. Altner, M.D. **CME credit:** AAFP Elective, 64 hours; AMA Category 1, 64 hours. **Fee:** $275. **Reg. limit:** 350. **Sponsor:** Cook County Graduate School of Medicine, 707 South Wood Street, Chicago, IL 60612. **Contact:** Robert J. Baker, M.D., Dean. **Phone:** 312-733-2800.

# CLASSIFIED ADVERTISING

## POSITIONS & PRACTICE OPPORTUNITIES

**OB-GYN, ENT, PEDIATRICS, SPECIALISTS** needed by 16-man multi-specialty clinic in university community of 50,000 in western Wisconsin; excellent retirement and fringe benefits; fine recreational opportunities; salary negotiable. Send curriculum vitae and references to: John R. Ujda, M.D., La Crosse Clinic, 212 South 11th Street, La Crosse, Wisconsin 54601.

**FULL TIME PHYSICIAN** for Industrial Clinic in Skokie. Surgical experience needed. Salary negotiable. Must have Illinois license. Call (312) 674-4800, Mrs. McCubbin.

**OPPORTUNITIES FOR PHYSICIANS IN INDIANA**—There are several excellent openings among the Indiana State Hospitals at various locations throughout the state for psychiatrists and physicians of other specialties, at most experience levels. A newly-revised salary schedule offers a very competitive income plus a generous package of fringe benefits. An adjunct practice is possible beyond the regular working hours and on-call responsibilities. Please reply with a copy of the c.v. to: Farabee & Associates, Inc., P.O. Box 472, Murray, KY 42071 or call (collect) (502) 753-9772. Farabee is retained by the Indiana Department of Mental Health.

**EMERGENCY PHYSICIAN, McHENRY:** Full-time career-oriented emergency physician to begin July 1 in 17,000 visit/year emergency department of 140-bed mobile-intensive-care resource hospital and trauma center 50 miles northwest of Chicago. Small town (pop. 8,000). Ski and water sports area. Good back-up from 20-man multi-specialty clinic in adjacent building and from independent specialists in community. Salary and fringes competitive with Chicago area. Send curriculum vitae to: John L. Bowman, M.D., Director, Emergency Services, McHenry Hospital, 3516 W. Waukegan Road, McHenry, IL 60050.

**SOUTHERN MEDICAL CENTER** will be seeking a Family Practice physician and a General Internal Medicine physician with Illinois licenses or reciprocity status. The private practice is in a newly remodeled building for physicians and allied health services. Excellent salary guarantee with participation in excess, fringe benefits. Office expenses and malpractice paid. Hospital will pay recruiting expenses for physician and family. Call 618/734-2400 or write Harvey H. Pettry, Administrator, Southern Medical Center, 2020 Cedar Street, Cairo, IL 62914.

**ACADEMIC DIRECTOR, INTERNAL MEDICINE:** University of Illinois affiliated community hospital seeks individual to be responsible for undergraduate, graduate and continuing medical education, and administration of residency and outpatient center. Physician we seek must be American Board of Internal Medicine certified. In return we offer a challenging and rewarding experience plus a competitive salary and benefit program. Send resume in complete confidence to: Box 917, c/o IMJ, 55 E. Monroe, Suite 3510, Chicago 60603.

**GENERAL PRACTITIONER** for office-based practice with multi-specialty group in western suburbs of Chicago. Attractive minimum guarantee salary plus incentive. Complete fringe benefit package. Write for details: Dave S. Bauer III, Administrator, Glen Ellyn Clinic, S.C., 454 Pennsylvania Ave., Glen Ellyn, IL 60137.

**OTOLARYNGOLOGIST** to join large multi-specialty group as second ENT doctor in western suburbs of Chicago. Very busy practice. Guaranteed base salary plus incentive; Early partnership. Complete fringe benefit package. Box 91B, c/o IMJ, 55 E. Monroe, Suite 3510, Chicago, 60603.

**EMERGENCY PHYSICIAN:** Off-duty 3 weeks out of 5 weeks. Corporate group of 6, non-hospital employees, double physician coverage during peak loads, 40,000 visits yearly in autonomous emergency department. Salary $60,000, bonus, plus $31,500 in untaxed fringe benefits, including premiums for malpractice, disability family health & accident, $1,000,000 major medical, fringe benefit reimbursement, $50,000 life insurance policies, professional society dues, profit sharing & pension plan funds. Central Illinois college town, 100,000 population. Primarily interested in U.S. trained, emergency medicine career physician. Apply by submitting curriculum vita to: Box No. 919, c/o IMJ, 55 E. Monroe, Suite 3510, Chicago, 60603.

**INTERNIST AND FAMILY PHYSICIAN:** Established need for both an internist and family physician to join seven man group in beautiful Northwest Iowa. New clinic building of 10,000 sq. ft. is located next door to 88-bed county hospital. Unusually progressive community of 10,000 offers 3,000 acre lake, 85 acres of parks and recreation, local liberal arts college, and many family interest features. Generous salary with incentive, malpractice insurance, liberal vacation and seminar time, partnership in one year. Contact D. A. Pritchard, Administrator, Buena Vista Clinic, 620 Northwestern Drive, Storm Lake, Iowa 50588.

**WANTED: INDUSTRIAL PHYSICIAN:** Unusual opportunity for Illinois licensed physician. Full time industrial work with minor traumatic surgery and physical examinations. Regular hours. Advancement for right person. Starting salary negotiable. Write to Box 920, c/o IMJ, 55 E. Monroe, Suite 3510, Chicago, 60603.

**ANESTHESIOLOGIST:** population 11,000—service area 30,000. Home of Monmouth College. Sixteen miles from the Mississippi. Close to large metropolitan area. Modern, well-equipped hospital. Contact: Roger E. Gurholt, Administrator, Community Memorial Hospital, Monmouth, Illinois 61462 (309) 734-3141.

**PHYSICIAN WANTED:** Family Practitioner, Board Eligible or Certified, full time position. Chicago suburban group with complete diagnostic facilities. Excellent starting compensation. Profit sharing and pension program. Pleasant working conditions. Capable interested medical associates. Convenient location, regular hours, good hospital affiliation, vacations. Insurance benefits include life, hospitalization, catastrophic medical expense, disability and malpractice. Medical Society and hospital dues paid by corporation. Call collect: Eugene J. Scherba, M.D., or Administrator, Thomsen Clinic, Ltd. (312) 849-2400.

**CARBONDALE:** General Practitioner, Family Practitioner or Internist —for health service at prominent university which includes a school of medicine. Scenic recreational area combining the virtues of small town living with the cultural and shopping assets of a large metropolitan area. Attractive salary, 40-hour work week and generous fringe benefits. IL license required. A.A.E.O. employer. For further information send vitae to Don Knapp, M.D., Medical Director, SIU-C Health Service, Carbondale, IL 62901.

**RADIOLOGIST** needed immediately to assume leadership and development for professional radiology services in progressive 167-bed JCAH hospital. Pleasant community with exceptional recreational facilities, 90 miles west of Chicago. Outstanding opportunity for progressive radiologist to work with our staff of 38 physicians. Contact: Philip Hagan, Administrator, Community General Hospital Sterling, Il. 61081. (815) 625-0400.

**PHYSICIAN** with empathy toward college age population to practice general medicine in 38-bed accredited hospital with large outpatient clinic. Salary negotiable. Excellent fringe benefits. Contact L. W. Combs, M.D., Director. Purdue University Student Hospital, West Lafayette, IN, 47907. 317-749-2441 Equal Access/Equal Opportunity Employer.

**CHIEF PATHOLOGIST** wanted for 200-bed hospital in central Michigan. Salary is negotiable. If interested please send notice to Mr. Hugh D. Witham, Administrator, The Memorial Hospital, 826 W. King St., Owosso, Michigan 48867, or call 517-723-5211, Ext. 811.

## FOR SALE, LEASE OR RENT

**MEDICAL OFFICE** for rent, Moline, Illinois, downtown location. Present occupant retiring OB-GYN. 725 feet, reception room, business area, private office, three examining rooms, laboratory, storage and rest room. Basement 375 feet. Rest room, laboratory and drug room. Contact Warren R. Streed, D.D.S., 719 16th Street, Moline, Ill. 61265.

**MEDICAL CLINIC**—For rent, lease, or sale. Immediately available, retiring, take over practice, fully equipped modern brick building; well over $100,000 gross; 5 hospitals in area; full community cooperation; suitable for two; 25 miles south of State Capitol. For further information, contact Ted Lay Agency, Box 34, Girard, Illinois 62640. (217) 627-2515 or 627-2835.

**MODERN MEDICAL SUITE,** Homewood area: 800 sq. ft. available immediately. Reception plus 3 to 4 rooms, private bath. Panelled, carpet, air condition, all utilities paid and off-street parking. Convenient to all transportation and south suburban hospitals. Phone Mr. Olsen weekdays: 565-0025; Evenings: 798-8234.

**OFFICE TO SUBLET PART TIME:** professional building. Common waiting room with receptionist suitable for internist, psychiatrist, surgeon. To arrange days and hours call Monday, Tuesday, Thursday: 2-5. (312) 262-0399.

**SUBLEASE:** Part time-ophthalmologist's office. Completely furnished and equipped. (Garland Bldg.) Phone (312) 236-6368.

**MEDICAL OFFICE SUITE FOR RENT,** Lincoln-Belmont Bldg. 715 square feet, available July 1, 1978 in full service, elevator, active professional building. Call Gary Solomon, (312) 334-5400.

**FOUR ROOM MODERN SUITE** and waiting room. Medical Center, 10444 South Kedzie Avenue, Chicago, Ill. 60655, (312) 239-3000.

**MEDICAL CENTER FOR RENT.** Complete and ready to open. 4300 sq. ft. at 2301 E. 95th Street, Chicago. Large waiting rm., 18 exam rms., x-ray rm., central a/c & heat. Call Gary Solomon, (312) 334-5400.

**SUITE TO LEASE** for Internist, Pediatrician, Psychologist, Psychiatrist or other medical practice. Suite is located in a high quality building with a growing medical community situated across from a major hospital. The complex already includes an outstanding lab, X-ray facility, pharmacy and 16 professionals. Arrangement provides flexibility for the new tenant to share a suite with an existing practice, to have office built in newly created bare space and to participate in the ownership and direction of the complex. STRONG Property Managers, Ltd. Agents, 201 W. Springfield, Champaign, IL 61820. (217) 356-2617.

## SITUATIONS WANTED

**CONSIDERING STAFF ADDITIONS?** Medical Assistants available throughout the state. Robert Morris College has a Medical Assisting Program accredited by the Council on Medical Education of the American Medical Association in collaboration with the American Association of Medical Assistants. Our Medical Assistants are proficient in administrative, clinical, and laboratory areas. Graduates are prescreened prior to application. No fee charged to Employer or Applicant. Call: Toll Free 800-252-9151 or (217) 357-2121; Robert Morris College Placement Center, College Avenue, Carthage, IL 62321.

**EXPERIENCED ER PHYSICIAN** wants to join emergency room hospital group in permanent ER position. Please write Box 910, c/o IMJ, 55 E. Monroe, Suite 3510, Chicago, 60603.

**RADIOLOGIST** seeks permanent part-time position, 4 hrs/day, fluroscopy and/or film reading. Chicago metropolitan area. Please write Box 911, c/o IMJ, 55 E. Monroe, Suite 3510, Chicago, IL 60603.

**UNIVERSITY TRAINED, LICENSED,** board eligible pediatrician seeks opportunities in DuPage, Will or Kane County in the West Suburban Chicago area. Has worked in general hospital and children's hospital pediatrics, Emergency Room experienced. Available July, 1978. Reply to IMJ, Box 914 c/o IMJ, 55 E. Monroe, Suite 3510, Chicago, 60603.

**FAMILY PHYSICIAN,** board eligible, seeks to purchase a practice or associate with another family physician or group practice in Chicago or nearby suburb. Reply Box 915, c/o IMJ, 55 E. Monroe, Suite 3510, Chicago, 60603.

**SITUATION WANTED:** Illinois licensed physician's assistant seeks position with M.D., medical group or clinic. Good references. Salary negotiable. Will consider re-locating. Call 815-744-3650 (Joliet).

**UROLOGIST,** FMG, board certified university trained, FLEX, seeks solo or group practice, available July, 1978. Contact: P. Satpathy, M.D., 6517 Landover Road, #102, Cheverly MD. 20785. (202) 745-1315, (301) 773-0380.

**ATTENTION** small towns in northern half of Illinois: flying physician based in LaSalle County, will see outpatients in your clinic, one or two days weekly. Need 1000-foot sod landing area. Please write Box 923, c/o IMJ, 55 E. Monroe, Suite 3510, Chicago, 60603.

**DENTIST** looking to share office space with doctors—Northwest Suburbs or Northside Chicago. Will rent new space together or join in your existing location. Please call 312-729-1851.

**DIAGNOSTIC RADIOLOGY**—Board eligible. Well trained in ultrasound, CAT scan. Part or full time. Also for film reading. Call (312) 771-8076.

**CERTIFIED PHYSICIAN'S ASSISTANT IN MEDICINE:** Experienced and willing to learn, will relocate. Masood, 1260 West Bryn Mawr, Chicago, 60660. Telephone: 312-649-4561 (days) 769-4686 or 690-0544 (evenings).

## GUARANTY FUND CERTIFICATE

**GUARANTY FUND CERTIFICATE** for sale: Class 5, Territory 11 for $1,000,000/1,000,000 coverage, purchase price $6024. For information, call Mr. Murr (815) 963-9674 or send inquiries to Box 916, c/o IMJ, 55 E. Monroe, Suite 3510, Chicago, 60603.

**GUARANTY FUND CERTIFICATE,** Number 1901, Illinois State Medical Inter-Insurance Exchange for sale. Territory 1 Class 1, Purchase Price $772. Best offer, contact Donald Gordon, M.D., Lutheran General Hospital, 1775 Dempster Ave., Park Ridge, IL 60068; Tel. (312) 696-2210.

**GUARANTY FUND CERTIFICATE** No. 1828, ISMIE, original cost $876.00. Coverage for Internal Medicine, Gastroenterology, contact: Zayd Kaylani, M.D., 1740 West 27th, Suite 303, Houston, TX 77008.

**GUARANTY FUND CERTIFICATE** issued by the Illinois State Medical Inter-Insurance Exchange for sale. Coverage $100,000/$300,000. Class 5, Specialty: Otorhinolaryngology. Original purchase price $6,840.00. Interested: Contact Olawale O. Idewu, M.D. 9204 South Commercial Avenue, Chicago, Illinois 60617; Tel. (312) 735-8033 or 734-4243.

**GUARANTY FUND CERTIFICATE:** Class 4, Territory 1 for $1 Million/$1 Million. Moving out of state. Purchase price $2572 in 1976. Please reply to Box 921, c/o IMJ, 55 E. Monroe, Suite 3510, Chicago 60603.

**ILLINOIS STATE MEDICAL INTER-INSURANCE EXCHANGE GUARANTY FUND CETIFICATE.** For sale leaving Illinois—relocating. Medical specialty Anesthesiology, Class 5. $1 Million/$1 Million coverage, purchase price $10,000, Policy No. 204199. Favorable arrangements can be made. Send inquiries to Box 922, c/o IMJ, 55 East Monroe, Suite 3510, Chicago, 60603.

**GUARANTY FUND CERTIFICATE** #979 in territory 11 class 3. I retired from Medicine as of February 15, 1978. My investment in this certificate is $2572.00 and would prefer face value but will consider offers made. Vincent J. Kelly, M.D. Phone 815-937-4603.

**ISMIE GUARANTY FUND CERTIFICATE:** Price (original) $6024.00. Specialty: O8-GYN, Class V, Territory II. Have moved out of Illinois. Discount price. Will be available, Thomas T.H. Lin, M.D. 175 N. Jackson Ave., Suite 208, San Jose, CA 95116, (408) 251-5205.

**GUARANTY FUND CERTIFICATE:** Class 8 Inter-Insurance Exchange Certificate for sale (previously class 5). Call 266-1977, 9-5 P.M.

*IMJ and ISMS are not acting as brokers or agents; this is provided as a membership service.*




**RAVENSWOOD HOSPITAL MEDICAL CENTER**

**Primary Care: A View Toward the 80's**

*A 15-hour C.M.E. Credit Conference on the present and future directions of primary care medicine featuring discussions, lectures and case conferences on relevant primary care topics.*

For: Internists, Pediatricians, Family Practitioners.

August 17, 18, 19, 1978
A.M. SESSIONS ONLY

Interlaken Resort Lodge/Villas
Lake Geneva, Wisconsin

For further information, contact
Dept. of Medical Education
Ravenswood Hospital Medical Center
4550 N. Winchester at Wilson
Chicago, Illinois 60640
(312) 878-4300, Ext. 343

# STATE OF ILLINOIS,

EXECUTIVE DEPARTMENT

## Proclamation

*The lives and health of all our citizens is directly affected by the many professional medical assistants who support and assist practicing physicians and surgeons in rendering their services.*

*The American Association of Medical Assistants-Illinois Society is part of a national organization of medical assistants, including medical secretaries, nurses, technicians, receptionists, medical librarians and medical office managers. Its members are dedicated to upgrading their profession and improving their careers as valuable members of medical teams.*

*Their continuous efforts to maintain the highest standards of professional excellence by taking advantage of the many educational programs offered by the AAMA assures our citizens of receiving the best medical care possible.*

*The entire medical profession can be proud of the AAMA members' dedication to providing exceptional medical services to our citizenry.*

*THEREFORE, I, James R. Thompson, Governor of the State of Illinois, proclaim April 23-30, 1978, MEDICAL ASSISTANTS WEEK in Illinois. I commend these professionals for their fine service and urge all members of the medical profession and allied health fields to follow their example that Illinoisans may receive the best health care possible.*

In Witness Whereof, I have hereunto set my hand and caused the Great Seal of the State of Illinois to be affixed.

Done at the Capitol, in the City of Springfield, this FIFTEENTH day of MARCH, in the Year of Our Lord one thousand nine hundred and SEVENTY-EIGHT, and of the State of Illinois the one hundred and SIXTIETH



SECRETARY OF STATE

GOVERNOR

# Doctor's News

**PHYSICIANS IN THE NEWS**—Four Illinois physicians have been named to serve on a board of advisors to the Illinois Department of Public Health, Gov. James R. Thompson recently announced. **William D. McNobola, M.D.**, Wilmette, **Edward Jesse Jacobs, M.D.**, Arlington Heights, **Donald Jerome, M.D.**, Belleville and **Edward A. Brunner, M.D.**, Skokie, will serve on the Ambulatory Surgical Treatment Center Licensing Board. Members of the board do not receive a salary. . . . **William M. Lees, M.D.**, Lincolnwood and **Robert H. Reeder, M.D.**, Geneva, have been named to the Illinois Hospital Licensing Board. Members of that group review applications from hospitals to construct new or additional building facilities and report their findings to IDPH.

**Robert S. Mendelsohn, M.D.**, Chicago, was recently appointed medical director of American International Hospital in Zion. Doctor Mendelsohn, who writes a syndicated health column for several American newspapers, is an associate professor of preventive medicine and community health at the UI Abraham Lincoln School of Medicine in Chicago. . . . **Robert H. Libman, M.D.**, Chicago, has been selected one of ten "Outstanding Young Citizens," by the Chicago JAYCEES. Doctor Libman, who has written articles for the IMJ, is director of the Pain Clinic and also of education for the department of anesthesiology at Illinois Masonic Medical Center in Chicago.

Nine Illinois physicians have been cited for distinguished achievement by appointment as fellows of the American College of Radiology. **Glen D. Dobben, M.D.**, South Holland, **Michael S. Huckman, M.D.**, Evanston, **David B. Lewis, M.D.**, Springfield and **Daniel J. Murphy, M.D.**, Evanston, recently received that honor. Chicago physicians **William L. Schey, Alexander M. Bernstein, Abraham J. Flaxman, Edwin I. Hirsch,** and **Lawrence D. Scott,** were also chosen as fellows.

**WORLD CONGRESS ON DISEASES OF THE CHEST**—The International Academy of Physicians, an affiliate of the American College of Chest Physicians, has announced the thirteenth world congress on diseases of the chest, scheduled July 2-7 at the Kyoto International Conference Hall in Kyoto, Japan. U.S. participants include David T. Carr, M.D. and Robert S. Fontana of the Mayo Clinic in Minnesota. Dwight C. McGoon, M.D., head of the department of thoracic and cardiovascular surgery at the Mayo Clinic, has been chosen to receive one of four international awards during the congress. Physicians interested in attending the symposia may contact Alfred Soffer, M.D., executive director, American College of Chest Physicians, 911 Busse Highway, Park Ridge 60068.

**ANNUAL ART EXHIBIT**—The American Physician's Art Association will hold its annual exhibit in conjunction with the AMA annual meeting in St. Louis next month. The APAA, which boasts nearly 500 members, will exhibit the work of physicians in fields ranging from painting to photography and creative crafts. Judging also takes place at the convention. Membership is open to all interested physicians, and further information may be obtained from John Wm. Fries, M.D., APAA vice president, St. Anthony's Medical Center, 10010 Kennerly Road, St. Louis, MO 63128.

**DEPRESSION** will be topic of a three-hour closed circuit telecast scheduled from 3:00 to 6:00 p.m., on June 7. The telecast, sponsored by the Columbia University College of Physicians and Surgeons, is accredited for CME, and will be viewed in 26 American cities. Physicians viewing the program will be able to discuss pertinent questions with speakers. The Illinois telecast will be received at the Chicago Ambassador West Hotel, 1300 N. State Parkway, Guild Hall, from 3:00 to 6:00 p.m. Advanced registration is not required. The program is produced by Health Projects International, Inc., under a grant from Roche Laboratories, division of Hoffman-LaRoche, Inc.

**NO RATE INCREASE**—The Illinois State Medical Inter-Insurance Exchange has announced that no rate increases will be invoked at the July, 1978 policy renewal date. Rates for July, 1978-July, 1979 will not change.

**MEDICAL OFFICE MANAGEMENT** is the subject of a four-day seminar scheduled for June 5-8 in Chicago at the Chicago Marriott Hotel and sponsored by Conomikes Associates, Inc. Individual courses in management of personnel, patient flow and finances are available to interested physicians. The program fees for each are $180, $95 and $95 respectively. Enrollment for the entire four days would cost $350. For further information call, toll free: 800-421-6512.

**CONTROVERSIES IN LAW AND MEDICINE**—The American Society of Law and Medicine will present a symposium on medico-legal issues on June 3 in the President's Room of the Chicago Bar Association. Topics will include hospital requirements of "formal" malpractice coverage for staff physicians, availability of data and reports generated by institution-based peer review committees to the public and investigative attorneys, and use of life-prolonging treatment for incompetent patients. Registration is $55, and further information may be obtained from the American Society of Law and Medicine, 454 Brookline Avenue, Boston, MA 02215.

**PEDIATRICIANS TO HOLD MEETING**—The Illinois Chapter of the American Academy of Pediatrics will sponsor the 2nd Annual District VI Conference, June 23-25, 1978, Marriott's Lincolnshire Resort, Lincolnshire, Illinois. Eugene F. Diamond, M.D., Illinois Chapter president, and Joseph M. Garfunkel, M.D., Program Chairman have announced that the three-day session will feature lectures, round table discussions and general presentations in pediatrics. For further information, please contact Jean Althoff at the Chapter's offices, 55 East Monroe, Suite 3510, Chicago, Illinois 60603 (312/782-1654).

**CONTROLLED SUBSTANCE UPDATE**—The Illinois Dangerous Drugs Commission has rescheduled two drugs from Schedule III to Schedule II. Phencyclidine (PCP) and Pentazocine (Talwin) are the drugs concerned. Prescriptions for these drugs must now follow the full procedure for Schedule II substances, including triplicate prescription forms.

**IDPH NEWS**—The Illinois Department of Public Health has established a Health Care Facilities Resource Development Program under the supervision of George A. Lindsley, M.P.H., current secretary of the Health Facilities Planning Board. The program will seek to evaluate capital funding needs and resources for special types of health care facilities, work in shared services and consider capital funding programs in construction, modification and equipment for health care facilities.

## *President's Page*



# The Cost Challenge

The rising cost of medical care poses an unprecedented challenge for our profession. Critics charge that we are against cost control because physicians benefit when the status quo is preserved. We can concede half a point.

Physicians *are* against proposals designed to cut costs at the expense of quality medical care. But I believe the profession has demonstrated a willingness to support changes that will improve access and reduce costs without sacrificing quality.

Thus far government's approach to cost effectiveness does not coincide with our criteria, and most likely never will. However, we cannot wait for others to formulate acceptable programs. It's time to act. Inaction is an invitation for government to tighten its controls.

If the cost spiral continues, government schemes could enjoy substantial public support. On the other hand, effective voluntary action will defuse government's misdirected initiatives.

Two major voluntary approaches already are underway. The National Commission on the Cost of Medical Care has examined the cost dilemma and formulated wide-ranging recommendations. Approaching the problem from a slightly different angle is the National Steering Committee, a group formed by AMA, American Hospital Association and Federation of American Hospitals.

Portions of the National Commission's report have been sharply criticized by physicians. It was unrealistic to expect that all proposals would be actively supported or even passively accepted. But remember, we must be willing to take a hard look at our so-called "rights" and back some changes.

The Steering Committee has proposed a 15-point cost containment plan for hospitals that calls for action by medical staffs. The Committee now is shifting its focus to steps that can be taken in our individual practices. These recommendations undoubtedly will call for some tough decisions by physicians.

To direct implementations of its recommendations, the National Committee has called for creation of state steering committees. ISMS has responded by designating its Task Force on Cost Effectiveness to spearhead the drive in Illinois.

Efforts of the two national groups and the ISMS Task Force are commendable. But the key to winning the cost battle is the individual physician. Without his cooperation, the voluntary effort is doomed to fail.

I believe we can meet the challenge and voluntarily check the cost spiral. As your president, I pledge to vigorously promote workable cost effective programs, and to publicly denounce those schemes which place the dollar above quality care for our patients. I ask your support.

David S. Fox

David S. Fox, M.D., President



# membership forum

*Membership Forum is intended to serve as a communicative tool for ISMS Membership. The Editors encourage comment and criticism on issues of the day. Material published in this section reflects the personal opinions of individual ISMS members. The editor cannot accept responsibility for content. Publication does not reflect official policy or position of the Illinois State Medical Society or the Illinois Medical Journal. The right to edit materials, which should be limited to 300 words or less, is reserved.*

*Correspondence should be addressed to: IMJ, 55 E. Monroe, Suite 3510, Chicago 60603.*

## Census Form? Or Financial Statement?

Bureau of the Census
1201 E. Tenth Street
Jeffersonville, Missouri 47132

Sir:

Enclosed is my completed form CB-80A. I return it reluctantly, since it is obvious this form is not a census paper, but rather a financial statement. Further, it is an incomplete financial statement since it lists only those expenses relating to wages of employees, but omits such items as rent, insurance, medical supplies, and utilities.

At the top of this form there is the statement: "By the same law (Title 13, U.S. Code) your report to the Census Bureau is confidential." Considering the flagrant disregard for individual privacy and confidentiality by the Federal Government in recent years, I can only reach the following conclusions:

1. These "census" forms will be kept confidential, as stated by the Government.
2. The distorted financial information in these records will not be used by the Government to further harrass and libel the medical profession.
3. There really is a tooth fairy.

Sincerely,
Max Klinghoffer, M.D., Elmhurst

## Physicians' Duty

The Editor,
Illinois Medical Journal,
55 E. Monroe St.
Chicago, IL 60603

Dear Sir:

I read with interest the article by Dr. Linda L. Hughey in the Illinois Medical Journal for January 1978 (p. 14). Dr. Hughey stated that one of the complaints of resident physicians was the "unavailability of services and support mechanism." I also had this complaint in the hospital where I worked.

Before retirement I had practiced medicine for more than forty-five years. In the early years the doctor's word at his hospital was law and I maintain that that condition operated for the benefit of the patient. In this day of everyone being equal, the doctor no longer has such authority and important procedures must await the whims of ancillary personnel.

To illustrate, I once had an elderly lady with a Colles fracture. She was shocky and in severe pain. She sat unnecessarily outside the X-ray department, waiting for an X-ray until she fainted. There were three X-ray technicians and they did not have a patient. One was typing, one resting, and one riding up and do on the elevator. The large X- machine and a portable were av able. They just didn't care enough promptly take care of this acut injured patient.

Much has been said about Jehovah complex of physici working in hospitals. How or w we abrogated our authority I do know. If we are to be held resp sible for the welfare of our patie we must get it back.

Herman L. Meltzer, M
Clinton, Illi

## On Scoliosis

Editor
Illinois State Medical Journal

Dear Sir:

Let me warmly congratulate for your recent editorial arti "Early Screening for Spinal fects" in the November issue. Chairman of the Education C mittee of the Scoliosis Resea Society, which is an affiliate of American Academy of Orthopae Surgeons, I have been attempt to institute school screening spinal deformities and your art gives warm encouragement to th of us who have been trying to

ıte this public health measure. The surgery for adolescent idiohic scoliosis is a preventable ocrence and this fact and the sequences it has for the youngs and their families—physically, chologically and economically—uld persuade the medical comnity at large of the value of ool screening for scoliosis and hosis.

Again, my warm congratulations thanks for this support.

Yours sincerely,
William J. Kane, M.D.
Northwestern University
Medical School
Dept. of Orthopaedic Surgery
Chicago

## Clinical Note

Sir:

am writing in an attempt to spread nformation that sympathetic nerve k is efficacious in the care of acute herpes zoster.

Most importantly, early institution of this therapy greatly reduces the incidence of post herpetic neuralgia. As one who is asked to treat post herpetic pain, I am very much aware of the need for preventative therapy.

Yours truly,
Leo J. DeBacker, M.D., Champaign

## More on F.M.G.'s

Dear Dr. Hughey:

I enjoyed reading your article in the Illinois Medical Journal (153, No. 2:138) on the subject of F.M.G.'s. Of course, I'm prejudiced on the subject, as I have a son now a senior at Guadalajara.

The motivation to study in a foreign country, learn the language, and other obstacles, is a fact of life for me. I know the tremendous motivation this kid had to have. He lives and breaths medicine to attain his goal.

There is no way to satisfactorily screen medical school applicants. He was Captain of the varsity basketball team in his senior year at St. Ignatius school in Chicago. This hurt him, as he played so much basketball his fourth year that as a freshman in college he ended up with straight C's. He then found himself, and at the end of his senior year had a 3.17 average. But alas, too late.

His brother is an orthopedic surgeon, his uncle and two cousins are a surgeon and two orthopedic surgeons respectively. His drive to attain the profession he already loves is refreshing to see.

Your assessment of the problem was excellent. There are many good men to follow the highest standards of medicine. The medical school though, is the qualifying round. This they must have or the door is barred.

Enjoyed reading your article.
Sincerely,
Clifford P. Sullivan, M.D.
Chicago

★
*Specialized Service*
IN
PROFESSIONAL LIABILITY INSURANCE
*is a high mark of distinction*
THE
MEDICAL PROTECTIVE COMPANY
FORT WAYNE, INDIANA
*Professional Protection Exclusively since 1899*

CHICAGO AREA OFFICE:
T. J. Pandak, J. C. Kunches, L. R. Gannon, and W. G. Prangle, Representatives
814 Cammerce Drive, Suite 101B, Oak Brook, Illinois 60521 (312) 325-7314
SPRINGFIELD OFFICE: W. J. Nattermann, Representative
426½ South Fifth Street, Springfield 62701 (217) 544-2251

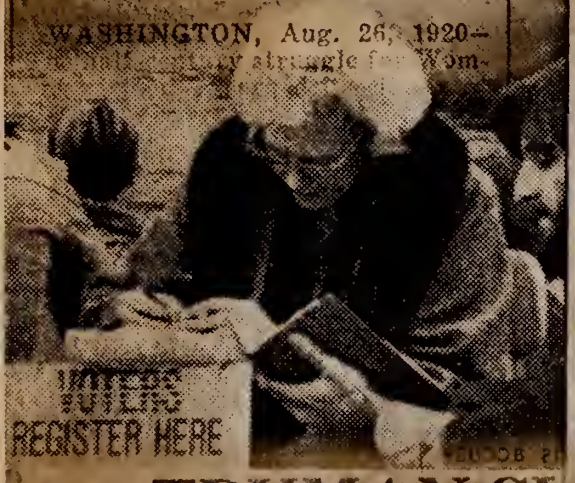
# COLBY PROCLAIMS WOMAN SUFFRAGE

Signs Certificate of Ratification at His Home Without Women Witnesses.

MILITANTS VEXED AT PRIVACY.

Wanted Movies of Ceremony, But Both Factions Are

WASHINGTON, Aug. 26, 1920—




# Social Security Bill Is Signe
# Gives Pensions to Aged, Jo

## Roosevelt Approves Message Intended to Benefit 30 Persons When States Adopt Cooperating Laws-H the Measure 'Cornerstone' of His Economic Prog

# SENATE APPROVES 18-YEAR OLD VOTE IN ALL ELECTIONS

Amendment to Constitution is Sent to House, Where Passage is Expected

WASHINGTON, March 10, 1971—The Senate approved today, 94 to 0, and sen

WASHINGTON, Aug
The Social Security Bil
a broad program of une
insurance and old ag
and counted upon to b
20,000,000 persons, bec
day when it was signe
dent Roosevelt in the
those chiefly responsib
ting it through Co

Mr. Roosevelt cal
"the cornerstone
which is being
me

# TRUMAN CLOSES ITED NATIONS CONFEREN WITH PLEA TO TRANSLATE CHARTER INTO DEEDS

## NEW WORLD HOPE

President Hails 'Great Instrument of Peace,' Insists It Be Used

HISTORIC LANDMARK

Meeting Gives Standing Ovation as Executive Pictures Peace Gain

"If we fail to use it," he declared to the solemn final meeting of the delegates, 'we shall betray all of those who have died in order that we might meet here in freedom and safety to create it.'

"If we seek to use it selfishly—for the advantage of any one nation or any small group of nations—we shall be equally guilty of that betrayal."

Fervent Interpolation

The President, speaking in the auditorium of the War Memorial Opera House, built in memory of sons of the Golden Gate city who gave their lives in the first World War, in which he himself served, seemed to give unconscious expression to the solemn feeling of the occasion when, at the outset of his speech, he interpolated the words, half a hope, half a prayer:

"Oh, what a great day this can be in history!"

Just before the plenary session

# IGN
# the Dra
# Ends N

WASHINGTON, Jan. 27, 1973—"With the signing of the peace agreement in Paris today, and after receiving a report from the



# PATIENT PACKAGE INSERTS: A CONCEPT WHOSE TIME HAS COME?

*The consumer's right to know is an irreversible and desirable trend of the Seventies. It extends, and properly, to a patient's right to know more about his or her prescription medications. One way, gaining favor, is through patient package inserts. Wisely-prepared and properly distributed when medically indicated, they could markedly improve patient knowledge and drug therapy—laudable goals by anyone's standards.*

*The PMA endorses these goals and will work with government, the health professions and consumers to achieve them.*

## The Advantages

The concept holds promise of benefits: better patient understanding of the product prescribed, better adherence to the treatment plan, and more awareness of possible side reactions.

Every doctor has had patients who fail to finish antibiotic regimens because they feel better. Some patients assume that if one tranquilizer or analgesic is good, two may be twice as good. Still others fail to report dizziness while on antihypertensive therapy —and so on.

Problems like these might arise less often if the patient received written information in addition to verbal instructions. Some studies suggest that patients are more receptive to such materials, and they more often understand the verbal instructions and follow them, when inserts are used.

## The Disadvantages

There are also some potential problems. Obviously, the inserts must be clearly phrased, without extraneous or complex detail. How much information is enough? How can it be kept current? Should all patients receive the same information? Should inserts be included with all drugs? Should only potential problems be listed or are patients better off with a "fair balance" presentation that describes usefulness as well as drawbacks?

These and similar questions require answers, since model inserts have yet to be properly developed and tested. Despite the need for these studies, the FDA is proceeding prematurely with inserts on selected products. We think the Congress is the only place where the matter can be given the proper legal status and direction, particularly since it represents a conceptual change in the legal, medical and social framework of the nation's prescription drug information system.

## *The Solution*

The PMA believes that carefully-devised pilot studies of various kinds of inserts are needed. They should be developed and implemented with full participation by doctors, pharmacists, consumers, communications experts and the drug industry. Such studies will provide reliable pathways to follow, so that inserts will be useful aids to medical practice.

And particularly we think that you should be closely involved in this debate and in these studies and decisions. Otherwise, people with less experience and qualifications may control the purposes, content and use of a tool with considerable promise for improved patient care. It could make a difference in your practice tomorrow, and more importantly, in the health of your patients.

PMA
THE PHARMACEUTICAL MANUFACTURERS ASSOCIATION
1155 FIFTEENTH ST. N W WASHINGTON, D C 20005

IMJ
Illinois Medical Journal

# YOUR ADVERTISERS

*Our advertisers serve the Medical Profession and support your Journal. All advertisers are approved by your Journal Committee. It will help you and your society to mention your Journal when writing them.*

## Space Representatives

United Media Associates, Inc., 16 Bruce Park Avenue, Greenwich, Conn. 06830

## Pharmaceuticals

| | | | |
|---|---|---|---|
| 348-350 | Boehringer Ingelheim<br>*Catapres* | 389 | Mead Johnson Laboratories<br>*Vasodilan* |
| 405 | Breon Laboratories<br>*Bronkodyl* | 390-392 | Mead Johnson Laboratories<br>*Quibron* |
| 406-407 | Bristol Laboratories<br>Div. of Bristol-Myers Co.<br>*Tegopen* | Covers 3&4 | Roche Laboratories<br>Div. of Hoffman-LaRoche<br>*Librium* |
| 340-341 | Burroughs Wellcome Co.<br>*Cardilate* | 339 | Roche Laboratories<br>Div. of Hoffman-LaRoche<br>*Valium* |
| Cover 2 | Burroughs Wellcome Co.<br>*Empirin Compound with Codeine* | 358 | Upjohn Pharmaceuticals<br>*Tolinase* |
| 353-354 | Geigy Pharmaceuticals<br>Div. of Ciba-Geigy Corp.<br>*Tofranil—P.M.* | 346-347 | Warren Teed Laboratories<br>*Kaon* |
| 400 | Eli Lilly and Co.<br>*Darvon* | 351 | Warren Teed Laboratories<br>*Modane* |

## Insurance

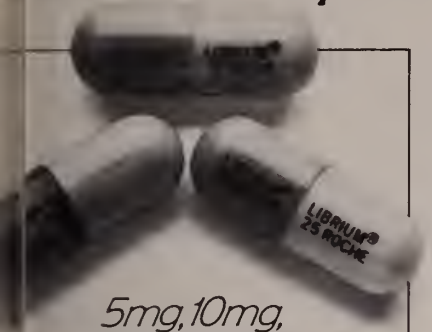
| | | | |
|---|---|---|---|
| 417 | Medical Protective Co.<br>*Professional Liability Ins.* | 357 | Parker Aleshire and Co.<br>*Group Insurance* |

## Services and Continuing Education

| | | | |
|---|---|---|---|
| 355 | Bio-Science Laboratories<br>*Laboratory Services* | 399 | Oak Forest Hospital<br>*Resident Programs* |
| 343-344 | Blue Cross and Blue Shield<br>Report | 357 | O'Hare International Autos<br>*Leasing Service* |
| 363 | Caterpillar Tractor Company<br>*Staff Physician Wanted* | 398 | Park West Medical Plaza<br>*Office Space* |
| 410-411 | Classified Advertising | 418-419 | Pharmaceutical Manufacturers<br>Association<br>*Patient Package Inserts* |
| 363 | Clover Leaf Towers<br>*Office Space* | 411 | Ravenswood Hospital<br>*Continuing Medical Education* |
| 386 | Cook County Graduate School<br>*Continuing Medical Education* | 403 | Rush Presbyterian-St. Luke's<br>Hospital<br>*Continuing Medical Education* |
| 408-409 | ISMS Guide to Continuing<br>Medical Education | 398 | U.S. Army<br>*Recruitment* |
| 401 | Jobst Institute<br>*Venous Pressure Gradient Supports* | | |
| 397 | Mann, Levine & Weiss<br>*Pension Consultants* | | |

# Librium®

## chlordiazepoxide HCl/Roche




5mg, 10mg, 25mg capsules

- ☐ Proven antianxiety performance
- ☐ An unsurpassed safety record
- ☐ Predictable patient response
- ☐ Minimal effect on mental acuity at recommended doses
- ☐ Minimal interference with many primary medications, such as antacids, anticholinergics, diuretics, cardiac glycosides and antihypertensive agents

**re prescribing, please consult complete product information, a summary of which follows:**

**ndications:** Relief of anxiety and tension occurring alone companying various disease states. Efficacy beyond months not established by systematic clinical studies. dic reassessment of therapy recommended.

**Contraindications:** Patients with known hypersensitivity e drug

**Warnings:** Warn patients that mental and/or physical abilrequired for tasks such as driving or operating maery may be impaired, as may be mental alertness in chiland that concomitant use with alcohol or CNS depresmay have an additive effect. Though physical and psygical dependence have rarely been reported on recomded doses, use caution in administering to addictionindividuals or those who might increase dosage; withal symptoms (including convulsions), following discontion of the drug and similar to those seen with barbies, have been reported.

**sage in Pregnancy: Use of minor tranquilizers during rst trimester should almost always be avoided beuse of increased risk of congenital malformations as ggested in several studies. Consider possibility of regnancy when instituting therapy; advise patients discuss therapy if they intend to or do become regnant.**

**Precautions:** In the elderly and debilitated, and in chilover six, limit to smallest effective dosage (initially 10 or less per day) to preclude ataxia or oversedation, ining gradually as needed and tolerated. Not recomded in children under six. Though generally not recomded, if combination therapy with other psychocs seems indicated, carefully consider individual pharlogic effects, particularly in use of potentiating drugs as MAO inhibitors and phenothiazines. Observe usual autions in presence of impaired renal or hepatic funcParadoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

**Adverse Reactions:** Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

**Usual Daily Dosage:** Individualize for maximum beneficial effects. Oral—Adults: Mild and moderate anxiety and tension, 5 or 10 mg t.i.d. or q.i.d.; severe states, 20 or 25 mg t.i.d. or q.i.d. Geriatric patients: 5 mg b.i.d. to q.i.d. (See Precautions.)

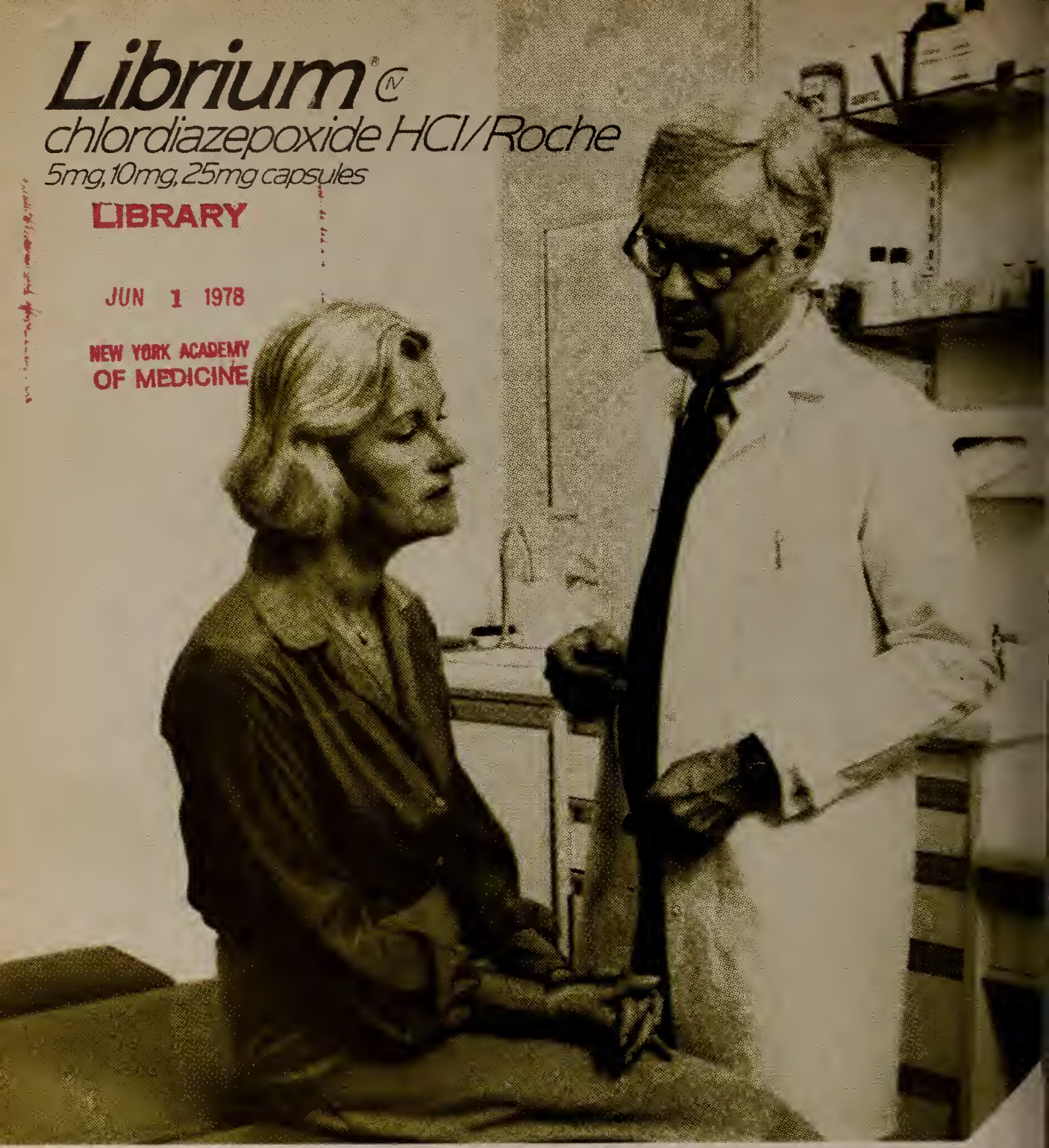
**Supplied:** Librium® (chlordiazepoxide HCl) Capsules, 5 mg, 10 mg and 25 mg—bottles of 100 and 500; Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10; Prescription Paks of 50, available singly and in trays of 10. Libritabs® (chlordiazepoxide) Tablets, 5 mg, 10 mg and 25 mg—bottles of 100 and 500. With respect to clinical activity, capsules and tablets are indistinguishable.

# ynonymous with relief of anxiety

ROCHE

Roche Products Inc.
Manati, Puerto Rico 00701

**Please see following page.**



# Librium®
## chlordiazepoxide HCl/Roche
5mg, 10mg, 25mg capsules

LIBRARY

JUN 1 1978

NEW YORK ACADEMY
OF MEDICINE

synonymous with relief of anxiet

ROCHE

Please see preceding page for a summary of product information.

Illinois Medical Journal

OFFICIAL JOURNAL OF THE ILLINOIS STATE MEDICAL SOCIETY

Volume 153, No. 6, June, 1978

BALCONY

## e Anatomy of dden Death

forensic pathologist s with a broad ety of natural and nt deaths in his to-day work. This y of 118 recent ners' autopsies in nwest Illinois brings nd an age-old truth. pathologist is tantly reminded and atedly impressed the fact that although is only one way in h to be born, there nany ways in which e... 447

## Complement Updated for the Clinician

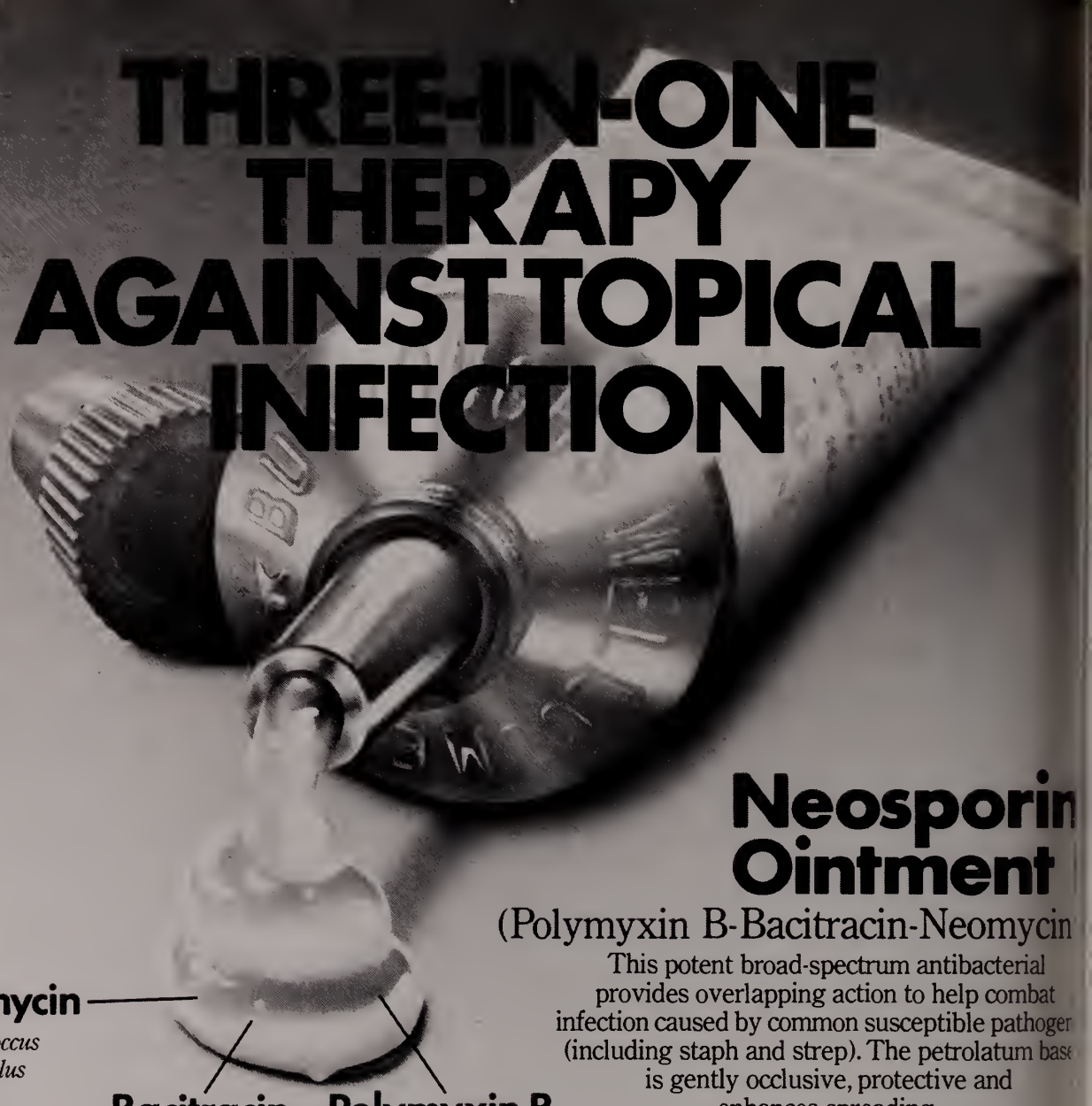
The estimation of complement in serum and other body fluids, particularly synovial fluid, now has an established place in the assessment, prognosis and response to treatment of diseases associated with immunological phenomena. This article reviews the complement sequence itself, factors which may affect the concentration of various components and the altered patterns which characterize various disease processes ... 455

## Benign Osteoblastoma

Benign Osteoblastoma is a rare vascular tumor which forms osteoid and bone. The incidence ratio of males to females is 2:1, and 80% of these patients are less than 30 years of age. Most of the lesions have developed in the spine or major long bones of the lower extremities. This case report is among less than 200 published cases in the literature ... 452

Table of Contents .... 421
President's Page ..... 486
Accumulative Index . 489

# THREE-IN-ONE THERAPY AGAINST TOPICAL INFECTION



## Neosporin Ointment

(Polymyxin B-Bacitracin-Neomycin

This potent broad-spectrum antibacterial provides overlapping action to help combat infection caused by common susceptible pathoger (including staph and strep). The petrolatum base is gently occlusive, protective and enhances spreading.

**Neomycin**

*Staphylococcus*
*Haemophilus*
*Klebsiella*
*Aerobacter*
*Escherichia*
*Proteus*
*Corynebacterium*
*Streptococcus*
*Pneumococcus*

**Bacitracin**

*Staphylococcus*
*Corynebacterium*
*Streptococcus*
*Pneumococcus*

**Polymyxin B**

*Pseudomonas*
*Haemophilus*
*Klebsiella*
*Aerobacter*
*Escherichia*

*In vitro* overlapping antibacterial action of Neosporin® Ointment (polymyxin B-bacitracin-neomycin).

Wellcome

Burroughs Wellcome C
Research Triangle Park
North Carolina 27709

---

## Neosporin® Ointment

(Polymyxin B-Bacitracin-Neomycin)

Each gram contains: Aerosporin® brand Polymyxin B Sulfate 5,000 units; zinc bacitracin 400 units; neomycin sulfate 5 mg (equivalent to 3.5 mg neomycin base); special white petrolatum qs; in tubes of 1 oz and 1/2 oz and 1/32 oz (approx.) foil packets.

**WARNING:** Because of the potential hazard of nephrotoxicity and ototoxicity due to neomycin, care should be exercised when using this product in treating extensive burns, trophic ulceration and other extensive conditions where absorption of neomycin is possible. In burns where more than 20 percent of the body surface is affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended.

When using neomycin-containing products to control secondary infection in the chronic dermatoses, it should be borne in mind that the skin is more liable to become sensitized to many substances, including neomycin. The manifestation of sensitization to neomycin is usually a low grade reddening with swelling, dry scaling and itching; it may be manifest simply as failure to heal. During long-term use of neomycin-containing products, periodic examination for such signs is advisable and the patient should be told to discontinue the product if they are observed. These symptoms regress quickly on withdrawing the medication. Neomycin-containing applications should be avoided for that patient thereafter.

**PRECAUTIONS:** As with other antibacterial preparation prolonged use may result in overgrowth of nonsus ceptible organisms, including fungi. Appropriate measur should be taken if this occurs.

**ADVERSE REACTIONS:** Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section).

Complete literature available on request from Profes sional Services Dept. PML.

IMJ

Illinois Medical Journal

JUNE, 1978 Vol. 153, No. 6 CONTENTS

489 Accumulative Index, Volume 153

## *Clinical Articles*

447 The Anatomy of Sudden Death
*by Harry W. Parks, M.D./Collinsville*

452 Case Report: Benign Osteoblastoma
*by Robert S. Kaminski, M.D. and Mohammad Munir Zaitoon, M.D./Berwyn*

## *Special Articles*

440 Generic Substitution To Be Implemented

## *Seminars in Immunopathology and Oncology*

455 Complement Updated for the Clinician
*Richard J. Ablin, Ph.D., Contributing Editor*
*by David G. Palmer, M.D./New Zealand*

## *Surgical Grand Rounds*

462 Gun Shot Wound to the Neck
*John M. Beal, M.D., Contributing Editor*

## *President's Page*

486 A New Look
*David S. Fox, M.D.*

*(Contents continued on overleaf)*

## *Features*


423 Clinics for Crippled Children
430 Viewbox
432 EKG of the Month
433 Editorial
443 Letters to the Editor
446 Housestaff News
467 Pulse of the ISMS Auxiliary
468 Illinois Society, American Association of Medical Assistants
470 ISMS Guide to Continuing Medical Education
472 Membership Forum
474 Physician Recruitment
476 Classified Advertising
481 Obituaries
487 Doctor's News


## *Staff*


**Managing Editor** . . . . . **Richard A. Ott**
**Assistant Editor** . . . . . **Mariann M. Stephens**
**Executive Administrator** . . . . . **Roger N. White**


*(Cover by Jane and C. R. Bushwaller)*


**PUBLICATIONS COMMITTEE**
Herschel Browns, M.D., Chicago, *Chairman*
Kenneth A. Hurst, M.D., Naperville
Robert P. Johnson, M.D., Springfield
Alfred J. Kiessel, M.D., Decatur
Harold J. Lasky, M.D., Chicago

**Editorial Board**
J. William Roddick, Jr., M.D., *Chairman*
Eli L. Borkon, M.D., Carbondale
Daniel R. Cunningham, M.D., Wilmette
Raymond A. Dieter, Jr., M.D., Glen Ellyn
James G. Ekeberg, M.D., Palatine
Ediz Z. Ezdinli, M.D., Kenilworth
Carl Neuhoff, M.D., Peoria
Constantine S. Soter, M.D., Arlington Heights
Donald D. VanFossan, M.D., Springfield

Contributor in Surgery: John M. Beal, M.D., Chicago
Contributor in Maternal Death Studies: Robert R. Hartman, M.D., Jacksonville
Contributor in Pediatric Perplexities: Ruth Andrea Seeler, M.D., Chicago
Contributor in Radiology: Leon Love, M.D., Maywood
Contributor in Cardiology: John R. Tobin, M.D., Maywood
Contributor in Immunopathology: Richard J. Ablin, Ph.D., Chicago
Contributor in Rbeumatology: L. F. Layfer, M.D., Chicago



ILLINOIS STATE MEDICAL SOCIETY

OFFICERS
David S. Fox, M.D., President
826 E. 61st St., Cbicago 60637
P. John Seward, M.D., President-Elect
310 N. Wyman St., Rockford 61101
Herschel Browns, M.D., 1st Vice-President
4600 N. Ravenswood, Chicago 60640
G. W. Giebelhausen, M.D., 2nd Vice-President
1101 Main St., Peoria 61606
Audley F. Connor, Jr., M.D., Secretary-Treasurer
7531 S. Stony Island Ave., Chicago 60649

HOUSE OF DELEGATES
Cyril C. Wiggishoff, M.D., Speaker
25 E. Washington, Chicago 60602
Robert P. Johnson, M.D., Vice-Speaker
108 Maple Grove, Springfield 62707

TRUSTEES
1st District: 1980, Jobn J. Ring, M.D.
511 Hawley, Mundelein 60060
2nd District: 1980, Allan L. Goslin, M.D.
712 N. Bloomington, Streator 61364
3rd District: 1979, Alfred Clementi, M.D.
675 W. Central Rd., Arlington Heights 60005
3rd District: 1980, Raymond J. Des Rosiers, M.D.
1044 N. Francisco, Chicago 60622
3rd District: 1979, Robert T. Fox, M.D.
2136 Robincrest, Glenview 60025
3rd District, 1979, Jere Freidheim, M.D.
3050 S. Wallace, Chicago 60616
3rd District: 1981, Morris T. Friedell, M.D.
7531 S. Stony Island Ave., Chicago 60649
3rd District: 1981, Henrietta Herbolsheimer, M.D.
5528 S. Hyde Park Blvd., Apt. 1202, Chicago 60637
3rd District: 1981, Lawrence L. Hirsch, M.D.
2434 Grace St., Chicago 60618
3rd District: 1980, Harold J. Lasky, M.D.
55 E. Washington, Chicago 60602
3rd District: 1980, Richard N. Rovner, M.D.
645 N. Michigan, Suite 920, Chicago 60611
3rd District: 1980, Joseph C. Sherrick, M.D.
303 E. Superior, Chicago 60611
4th District: 1979, Fred Z. White, M.D.
723 N. Second St., Chillicothe 61523
5th District: 1979, P. F. Mahon, M.D.
800 E. Carpenter, Springfield 62702
6th District: 1981, Robert R. Hartman, M.D.
1515 A. W. Walnut, Jacksonville 62650
7th District: 1979, Alfred J. Kiessel, M.D.
1 Powers Lane Pl., Decatur 62522
8th District: 1979, James Laidlaw, M.D.
104 W. Clark, Champaign 61820
9th District: 1981, Warren D. Tuttle, M.D.
203 N. Vine St., Harrisburg 62946
10th District: 1981, Julian W. Buser, M.D.
6600 W. Main St., Belleville 62223
11th District: 1980, Kenneth A. Hurst, M.D.
52 Bunting Lane, Naperville 60540
12th District: 1980, Joseph Perez, M.D.
5670 E. State St., Rockford 61108
Trustee-At-Large: George T. Wilkins, M.D.
3165 Myrtle, Granite City 62040
Chairman of the Board: Robert R. Hartman, M.D.
1515 A. W. Walnut, Jacksonville 62650



Microfilm copies of current as well as some back issues of the *Illinois Medical Journal* may be purchased from Xerox University Microfilm, 300 North Zeeb Road, Ann Arbor, Mich. 48106.

Contents of *IMJ* are listed in the *Current Contents/Clinical Practice.*

Published by the Illinois State Medical Society, 55 E. Monroe St., Chicago, Ill. 60603 (312-782-1654)



Copyright, 1978. The Illinois State Medical Society. All material subject to this copyright may be photocopied for the noncommercial purpose of scientific or educational advancement.



Subscription $8.00 per year, in advance, postage prepaid, for the United States, Cuba, Puerto Rico, Philippine Islands and Mexico. $10.00 per year for all foreign countries included in tbe Universal Postal Union. Canada $8.50. U.S. Single current copies available at $1.00 ($1.10 by mail), back issues $1.50.

Second class postage paid at Chicago, Ill. When moving please notify Journal office of new address including old mailing label with notification, if possible. POSTMASTER: Send notice on form No. 3579 to Illinois State Medical Society, 55 E. Monroe St., Chicago, Ill. 60603.

Pharmaceutical advertising must be approved by the ISMS Publications Committee. Other advertising accepted after review by Publications Committee or Board of Trustees. All copy or plates must reach the Journal office by the fifteenth of the month preceding publication. Rates furnished upon request.

Original articles will be considered for publication with the understanding that they are contributed only to the *Illinois Medical Journal.* The ISMS denies responsibility for opinions and statements expressed by authors or in excerpts, other than editorial or allied views or statements which reflect the autboritative action of the ISMS or of reports on official actions, policies or positions. Views expressed by autbors do not necessarily represent those of the Society; any connection with official policies is coincidental.

The *Illinois Medical Journal* is published by the Illinois State Medical Society as an educational and professional informational magazine and distributed as a benefit of membership in the Illinois State Medical Society. Its intent is to keep members current in medical knowledge and is a part of a continuing medical education program. Socioeconomic matters, affecting as they do a cbanging pattern in the proper delivery of medical care, are considered an inherent element in medical education.

# Clinics for Crippled Children Listed for July

Thirty-one clinics for Illinois' physically handicapped children have been scheduled for July by the University of Illinois, Division of Services for Crippled Children. The Division will count twenty-two general clinics providing diagnostic orthopedic, pediatric, speech and hearing examination, along with medical social and nursing services. There will be nine special clinics for children with cardiac conditions. Any private physician may refer to or bring to a convenient clinic any child or children for whom he may want examination or consultative services.

July 5 Hinsdale—Hinsdale Sanitarium
July 6 Effingham—St. Anthony Memorial Hospital
July 6 Lake County Cardiac—Victory Memorial Hospital
July 7 Division Cardiac—U. of I. at the Medical Center
July 10 Peoria Cardiac—St. Francis Hospital
July 11 Quincy—St. Mary's Hospital
July 11 Peoria—St. Francis Hospital
July 11 East St. Louis—Christian Welfare Hospital
July 11 Park Ridge Cardiac—Lutheran General Hospital
July 12 Champaign-Urbana—McKinley Hospital
July 12 Joliet—St. Joseph's Hospital
July 12 Chicago Heights General—St. James Hospital
July 13 DuQuoin—Marshall Browning Hospital
July 13 Springfield—St. John's Hospital
July 13 Macomb—McDonough District Hospital
July 14 Chicago Heights Cardiac—St. James Hospital
July 17 Maywood—Loyola Medical Center
July 18 Rock Island—Moline Public Hospital
July 18 Decatur—Decatur Memorial Hospital
July 18 Belleville—St. Elizabeth's Hospital
July 19 Rockford—St. Anthony's Hospital
July 19 Springfield—St. John's Hospital
July 19 Evergreen Park—Little Company of Mary Hospital
July 20 Elmhurst Cardiac—Memorial Hospital of DuPage County
July 21 Kankakee Cardiac—St. Mary's Hospital
July 24 Peoria Cardiac—St. Francis Hospital
July 25 Peoria—St. Francis Hospital
July 26 Centralia—St. Mary's Hospital
July 26 Elgin—Sherman Hospital
July 26 Chicago Heights General—St. James Hospital
July 28 Chicago Heights Cardiac—St. James Hospital

The Division of Services for Crippled Children is the official state agency established to provide medical, surgical, corrective and other services and facilities for diagnosis, hospitalization and after-care for children with crippling conditions or who are suffering from conditions that may lead to crippling. In carrying on its program, the Division works cooperatively with local medical societies, hospitals, the Illinois Children's Hospital-School, civic and fraternal clubs, visiting nurse association, local social and welfare agencies, local chapters of the National Foundation and other interested groups. In all cases, the work of the Division is intended to extend and supplement, not supplant, activities of other agencies, either public or private, state or local, carried on in behalf of crippled children.



**Librax®**
Each capsule contains 5 mg chlordiazepoxide HCl and 2.5 mg clidinium Br.

**Please consult complete prescribing information, a summary of which follows:**

**Indications:** Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

"Possibly" effective: as adjunctive therapy in the treatment of peptic ulcer and in the treatment of the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.

Final classification of the less-than-effective indications requires further investigation.

**Contraindications:** Glaucoma, prostatic hypertrophy, benign bladder neck obstruction; hypersensitivity to chlordiazepoxide HCl and/or clidinium Br.

**Warnings:** Caution patients about possible combined effects with alcohol and other CNS depressants, and against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Physical and psychological dependence rarely reported on recommended doses, but use caution in administering Librium® (chlordiazepoxide HCl) to known addiction-prone individuals or those who might increase dosage, withdrawal symptoms (including convulsions) reported following discontinuation of the drug.

***Usage in Pregnancy:*** **Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy. Advise patients to discuss therapy if they intend to or do become pregnant.**

As with all anticholinergics, inhibition of lactation may occur.

**Precautions:** In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship not established.

**Adverse Reactions:** No side effects or manifestations not seen with either compound alone reported with Librax. When chlordiazepoxide HCl is used alone, drowsiness, ataxia, confusion may occur, especially in elderly and debilitated, avoidable in most cases by proper dosage adjustment, but also occasionally observed at lower dosage ranges. Syncope reported in a few instances. Also encountered: isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent, generally controlled with dosage reduction; changes in EEG patterns may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice, hepatic dysfunction reported occasionally with chlordiazepoxide HCl, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax typical of anticholinergic agents, *i.e.*, dryness of mouth, blurring of vision, urinary hesitancy, constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.

ROCHE
Roche Products Inc.
Manati, Puerto Rico 00701


Anxiety...
Often a significant feature
of irritable bowel syndrome*
The action of
Librium®
(chlordiazepoxide HCl)
A significant advantage
of adjunctive
Librax®
Each capsule contains
5 mg chlordiazepoxide HCl and
2.5 mg clidinium Br.
Antianxiety
Antisecretory
Antispasmodic
Librax is unique among G.I. medications in providing the specific antianxiety action of Librium® (chlordiazepoxide HCl) as well as the potent antisecretory and antispasmodic actions of Quarzan® (clidinium Br) for adjunctive therapy of irritable bowel syndrome* and duodenal ulcer.*
*Librax has been evaluated as possibly effective for this indication.
Please see brief summary of prescribing information on preceding page.
ROCHE

# Awake on the job, yet anxieties resolved



## Troublesome drowsiness uncommon

Tranxene lets you manage anxiety in most patients without problem sedation. Any initial drowsiness is usually transient.

## Calming without impairment

Patients not oversedated can function better on the job*or at home. By avoiding excessive sedation, Tranxene helps you calm patients without compromising their capacities.

**Tranxene®**
(CLORAZEPATE DIPOTASSIUM)

C IV

4306CB

*Of course patients should be cautioned against hazardous tasks requiring mental alertness. See overleaf for prescribing information.

ABBOTT

8033249R

# Tranxene® Ⓒ Ⓘⓥ

(CLORAZEPATE DIPOTASSIUM) 4306CB

CAPSULES,
SINGLE DOSE TABLETS

**Brief Summary**

**ACTIONS** — Pharmacologically, clorazepate dipotassium has the characteristics of the benzodiazepines. It has depressant effects on the central nervous system. The primary metabolite, nordiazepam, quickly appears in the blood stream. The serum half-life is about 2 days. The drug is metabolized in the liver and excreted primarily in the urine. (See CLINICAL PHARMACOLOGY section.)

**INOICATIONS** — TRANXENE is indicated for the symptomatic relief of anxiety associated with anxiety neurosis, in other psychoneuroses in which anxiety symptoms are prominent features, and as an adjunct in disease states in which anxiety is manifested.

TRANXENE is indicated for the symptomatic relief of acute alcohol withdrawal.

The effectiveness of TRANXENE in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should reassess periodically the usefulness of the drug for the individual patient.

**CONTRAINOICATIONS** — TRANXENE is contraindicated in patients with a known hypersensitivity to the drug, and in those with acute narrow angle glaucoma.

**WARNINGS** — TRANXENE is not recommended for use in depressive neuroses or in psychotic reactions.

Patients on TRANXENE should be cautioned against engaging in hazardous occupations requiring mental alertness, such as operating dangerous machinery including motor vehicles.

Since TRANXENE has a central nervous system depressant effect, patients should be advised against the simultaneous use of other CNS-depressant drugs, and cautioned that the effects of alcohol may be increased.

Because of the lack of sufficient clinical experience, TRANXENE is not recommended for use in patients less than 18 years of age.

*Physical and Psychological Dependence:*

Withdrawal symptoms (similar in character to those noted with barbiturates and alcohol) have occurred following abrupt discontinuance of clorazepate. Symptoms of nervousness, insomnia, irritability, diarrhea, muscle aches and memory impairment have followed abrupt withdrawal after long-term use of high dosage.

Caution should be observed in patients who are considered to have a psychological potential for drug dependence.

Evidence of drug dependence has been observed in dogs and rabbits which was characterized by convulsive seizures when the drug was abruptly withdrawn or the dose was reduced; the syndrome in dogs could be abolished by administration of clorazepate.

*Usage in Pregnancy:*

**An increased risk of congenital malformations associated with the use of minor tranquilizers (chlordiazepoxide, diazepam, and meprobamate) during the first trimester of pregnancy has been suggested in several studies. TRANXENE, a benzodiazepine derivative, has not been studied adequately to determine whether it, too, may be associated with an increased risk of fetal abnormality. Because use of these drugs is rarely a matter of urgency, their use during this period should almost always be avoided. The possibility that a woman of childbearing potential may be pregnant at the time of institution of therapy should be considered. Patients should be advised that if they become pregnant during therapy or intend to become pregnant they should communicate with their physician about the desirability of discontinuing the drug.**

*Usage during Lactation:*

TRANXENE should not be given to nursing mothers since it has been reported that nordiazepam is excreted in human breast milk.

**PRECAUTIONS** — In those patients in which a degree of depression accompanies the anxiety, suicidal tendencies may be present and protective measures may be required. The least amount of drug that is feasible should be available to the patient.

Patients on TRANXENE for prolonged periods should have blood counts and liver function tests periodically. The usual precautions in treating patients with impaired renal or hepatic function should also be observed.

In elderly or debilitated patients, the initial dose should be small, and increments should be made gradually, in accordance with the response of the patient, to preclude ataxia or excessive sedation.

**AOVERSE REACTIONS** — The side effect most frequently reported was drowsiness. Less commonly reported (in descending order of occurrence) were: dizziness, various gastrointestinal complaints, nervousness, blurred vision, dry mouth, headache, and mental confusion. Other side effects included insomnia, transient skin rashes, fatigue, ataxia, genitourinary complaints, irritability, diplopia, depression and slurred speech.

There have been reports of abnormal liver and kidney function tests and of decrease in hematocrit.

Decrease in systolic blood pressure has been observed.

**OOSAGE ANO AOMINISTRATION**

*For the symptomatic relief of anxiety:*

TRANXENE is administered orally. The capsules may be given in divided doses. The usual daily dose is 30 mg. The dose should be adjusted gradually within the range of 15 to 60 mg. daily in accordance with the response of the patient. In elderly or debilitated patients it is advisable to initiate treatment at a daily dose of 7.5 to 15 mg.

TRANXENE capsules may also be administered as a single dose da bedtime; the recommended initial dose is 15 mg. After the initial dos response of the patient may require adjustment of subsequent do Lower doses may be indicated in the elderly patient. Drowsiness may at the initiation of treatment and with dosage increment.

TRANXENE-SD tablets (22.5 mg.) may be administered as a single every 24 hours. This tablet is intended as an alternate dosage form fc convenience of patients stabilized on a dose of 7.5 mg. capsules three t a day. TRANXENE-SD tablets should not be used to initiate therapy.

TRANXENE-SD HALF STRENGTH tablets (11.25 mg.) may be ministered as a single dose every 24 hours.

*For the symptomatic relief of acute alcohol withdrawal:*

Recommended schedule: 1st 24 hours, 30 mg. TRANXENE initially, follc by 30 to 60 mg. in divided doses; 2nd 24 hours, 45 to 90 mg. in div doses; 3rd 24 hours, 22.5 to 45 mg. in divided doses; 4th day, 15 to 3C in divided doses. Thereafter gradually reduce to 7.5 to 15 mg. daily, discontinue as soon as condition is stable. Maximum daily dose is 90 Avoid excessive reductions in total drug on successive days.

**ORUG INTERACTIONS** — If TRANXENE is to be combined with other d acting on the central nervous system, careful consideration should be g to the pharmacology of the agents to be employed. Animal experience cates that TRANXENE prolongs the sleeping time after hexobarbital or ethyl alcohol, increases the inhibitory effects of chlorpromazine, but not exhibit monoamine oxidase inhibition. Clinical studies have show creased sedation with concurrent hypnotic medications. The actions o benzodiazepines may be potentiated by barbiturates, narco phenothiazines, monoamine oxidase inhibitors or other antidepressant

If TRANXENE is used to treat anxiety associated with somatic dis states, careful attention must be paid to possible drug interaction with comitant medication.

**MANAGEMENT OF OVEROOSAGE** — Overdosage is usually manifeste varying degrees of CNS depression ranging from slight sedation to coma in the management of overdosage with any drug, it should be borne in r that multiple agents may have been taken.

There are no specific antidotes for the benzodiazepines. The treatmer overdosage should consist of the general measures employed in the n agement of overdosage of any CNS depressant. Gastric evacuation eithe the induction of emesis, lavage, or both, should be performed immedia General supportive care, including frequent monitoring of the vital s and close observation of the patient, is indicated. Hypotension, tho rarely reported, may occur with large overdoses. In such cases the us agents such as Levophed® (levarterenol) or Aramine® (metaraminol) sh be considered.

While reports indicate that individuals have survived overdoses TRANXENE (clorazepate dipotassium) as high as 450 to 675 mg., t doses are not necessarily an accurate indication of the amount of drug sorbed since the time interval between ingestion and the institution of tr ment was not always known. Sedation in varying degrees was the n common physiological manifestation of TRANXENE overdosage. Deep c when it occurred was usually associated with the ingestion of other drug addition to TRANXENE.

**CLINICAL PHARMACOLOGY** — Studies in healthy men have shown t TRANXENE has depressant effects on the central nervous syst Prolonged administration of single daily doses as high as 120 mg. without toxic effects. Abrupt cessation of high doses was followed in s patients by nervousness, insomnia, irritability, diarrhea, muscle aches memory impairment.

*Absorption — Excretion:*

After oral administration of TRANXENE, there is essentially no circulat parent drug. Nordiazepam, its primary metabolite, quickly appears in blood stream. In 2 volunteers given 15 mg. (50 $\mu$C) of $^{14}$C-TRANXE about 80% was recovered in the urine and feces within 10 days. Excret was primarily in the urine with about 1% excreted per day on day 10.

**HOW SUPPLIEO** — TRANXENE (clorazepate dipotassium) is supplied capsules in three dosage strengths:

3.75 mg. capsules (gray with white cap) in bottles of 100 (N 0074-3417-13) and 500 (NDC 0074-3417-53). Also available in ABE PAC® unit dose packages of 100 capsules (NDC 0074-3417-11).

7.5 mg. capsules (gray with maroon cap) in bottles of 30 (N 0074-3418-30), 100 (NDC 0074-3418-13) and 500 (NDC 0074-3418-5 Also available in ABBO-PAC unit dose packages of 100 capsules (N 0074-3418-11).

15 mg. capsules (all gray) in bottles of 100 (NDC 0074-3419-13) and 5 (NDC 0074-3419-53). Also available in ABBO-PAC unit dose packages 100 capsules (NDC 0074-3419-11).

TRANXENE-SD single dose tablets are supplied in two dosage strength

TRANXENE-SD 22.5 mg. tablets (tan-colored) in bottles of 100 (N 0074-2997-13).

TRANXENE-SD HALF STRENGTH 11.25 mg. tablets (blue-colored) in bott of 30 (NDC 0074-2699-30) and 100 (NDC 0074-2699-13).

Blue Cross®
Blue Shield®

# REPORT FOR *Illinois Physicians*

## New Options in State of Illinois Employees Program

Illinois Blue Cross and Blue Shield has again been selected to administer the group health insurance program for State of Illinois employees and dependents. The new contract is for two years, effective July 1, 1978 through June 30, 1980.

For the first time, employees may also choose between the state insurance program of Blue Cross and Blue Shield and the Health Maintenance Organization programs provided by participating medical groups and hospital facilities.

Employees enrolling in the alternate HMO programs will receive Blue Cross-Blue Shield membership identification cards with a special group number. It will be shown on the employee's ID card with the subscriber number. Health Assurance Plan (HAP) in Metropolitan Chicago area will issue two cards: one showing HAP membership and the second, a Blue Cross-Blue Shield membership ID card for use in emergencies away from the employee's HAP service area. Benefit brochures will be available to employees from the State agencies.

Group numbers are being assigned to the following participating organizations:

The Abraham Lincoln Health System, (Logan County); Health Assurance Plan (HAP) with 15 medical groups and 20 locations in the Metropolitan Chicago Area; The Foundation for Medical Care, (Sangamon, Menard, Morgan and Scott Counties) in Illinois.

Members enrolled in the Blue Cross-Blue Shield Illinois Employees Group Insurance Program will be issued Blue Cross and Blue Shield membership identification cards with the Group Number 42500.

The state group health insurance program provides three coverage options: Employee Only; Employee and High Option Dependent; and the Low Option Dependent plan, under Blue Cross-Blue Shield and Major Medical Expense benefits.

Throughout the program, payment of employee claims is based on the Usual and Customary fee of physicians or other professional providers rendering eligible services.

The State option plans are summarized below:

STATE OF ILLINOIS GROUP HEALTH INSURANCE PROGRAM

| Coverage | Employee & High Option Dependent | Low Option Dependent |
|---|---|---|
| Maximum Deductible | $200 For Employee only<br>$400 For Employee & Family | No Maximum Deductible |
| | **INPATIENT BENEFITS** | |
| 1. Room and Board | $125 maximum for semi-private room; (over $125 see Major Medical), no limit on number of days; $50 deductible. | $125 maximum for semi-private room, 120 days per person, $25 deductible, over 120 days covered under Major Medical, but only to $125 per day. |
| 2. Hospital Extras | Paid in full—(no comfort items) | Paid in full—(no comfort items) charges over 120 days covered under Major Medical. |
| 3. Intensive Care Unit | Paid in full, 365 days. | Paid in full; charges over 120 days covered under Major Medical. |
| 4. Extended Care Facility | Full cost when medically necessary; room & extras paid as 1 & 2 above. | Full cost when medically necessary; room & extras paid as 1 & 2 above. |
| 5. Maternity* | Room & hospital extras paid as 1 & 2 above; Obstetrician 80% of Usual and Customary fee | Room & hospital extras paid as 1 & 2 above; delivery allowances: normal $200; Caesarian $400. |
| 6. Nervous & Mental Disorders | Full cost to $25,000 per contract year. | Full cost to $10,000 per contract year. |
| 7. Surgery Fees* | 80% U&C of first $1,000<br>100% U&C over $1,000. | 80% of U&C fee. |
| 8. Professional Services* | $100 deductible<br>80% U&C $100-$1,000<br>100% U&C over $1,000 | Covered under Major Medical. |
| | **OUTPATIENT BENEFITS** | |
| 1. Outpatient Technical Procedures | 100% U&C coverage (but there is a maximum of $600 for 1, 2, & 3). Excess covered under Major Medical benefits. | 100% U&C up to $100 for each accident and $100 for all illnesses. Excess covered under Major Medical. |

***(Continued on following page)***

 *(Continued from preceding page)*

| Coverage | Employee & High Option Dependent | Low Option Dependent |
|---|---|---|
| | OUTPATIENT BENEFITS CONTINUED | |
| 2. Accidental Injury or Emergency Care | 100% U&C within 72 hours (but there is a maximum of $600 for 1, 2, & 3). Other visits covered under 4 below. | 100% U&C up to $300 within 72 hours. Excess covered under Major Medical. |
| 3. Ambulance Expenses | Accident—100% U&C if within 72 hours (but there is a maximum of $600 for 1, 2, & 3). All others, if medically necessary, covered under Major Medical. | Accident—100% U&C if within 72 hours (but there is a maximum of $300 for 2 & 3). All others, if medically necessary, covered under Major Medical. |
| 4. Professional Services* | $100 deductible per person per year<br>80% U&C of first $1,000<br>100% U&C over $1,000 | Covered under Major Medical. |
| 5. Outpatient Surgery* | 80% U&C of first $1,000<br>100% U&C over $1,000 | 80% of U&C fee. |
| 6. Nervous & Mental Disorders* | 50% U&C up to $25 per visit; limit of 1 per calendar week. | 2 visit deductible; 50% U&C up to $25 per visit; 1 visit per calendar week. |
| | OTHER BENEFITS | |
| | Major Medical | Major Medical |
| — Benefits | $50 deductible per person per year (subject to maximum above)<br>80% U&C from $50 to $1,000<br>100% U&C over $1,000 | $100 deductible per person per year<br>80% U&C of first $15,000; 100% U&C from $15,000 to $250,000; maximum $250,000. |
| — Coverage | Semi-private room charges over $125; prescription drugs; medical equipment & supplies; prosthetic appliances; physical therapy; renal dialysis; ambulance services; outpatient technical procedures over $600. | Charges for room over 120 days; Physician services (all); ambulance service; prescription drugs; renal dialysis; emergency care in excess of $300; prosthetic appliances; medical equipment & supplies; technical procedures in excess of $100. |

*Note: Payment is based on Usual and Customary fee of physicians or other professional providers rendering eligible services.

## ASK BLUE SHIELD . . . ABOUT MEDICARE

### Notices on Laboratory Changes

Notices were received from the Medicare Bureau on participation of new laboratories in the Medicare program and changes in approved specialties and subspecialties of laboratories in the program.

**Approved for Participation:**

Del Clinical Laboratory, 6259 South Cottage Grove, Chicago 60637 (Provider No. 14-8354) has been approved for participation under the Medicare program to perform the following tests and procedures: 310-Chemistry Routine; 320-Clinical Microscopy, 400-Hematology, and 630-Diagnostic Cytology. The effective date is March 22, 1978.

Mosquera Clinical Laboratory, 4255 West 63rd Street, Chicago 60629 (Provider No. 8350) has been approved for participation in the Medicare program to perform the following tests and procedures: 400-Hematology; 200-Serology Other; 630-Diagnostic Cytology; 310 Chemistry Routine; 320-Clinical Microscopy. Effective date: January 20, 1978.

Tree Town Clinical Laboratory, 4616 North Western Ave., Chicago 60625 (Provider No. 14-8351) has been approved for Medicare program participation for the following tests and procedures: 110-Bacteriology; 130-Parasitology; 200-Serology; 400-Hematology; 310-Chemistry Routine; 320-Clinical Microscopy; 510-Blood Group & Rh; 630- Diagnostic Cytology; 700-EKG Services. Effective date: February 2, 1978.

Presbyterian Home Laboratory, 3200 Grant Street, Evanston 60201 (Provider No. 14-8352) has been approved for Medicare program participation for the following tests and procedures: 310-Chemistry Routine; 320-Clinical Microscopy; 400-Hematology; 710-EKG Services. Effective date: November 30, 1977.

Rockford School of Medicine, 1601 Parkview Ave., Rockford 61101 (Provider No. 14-8353) has been approved for Medicare program participation for the following test and procedure: 110-Bacteriology; 140-Virology. Effective date: January 4, 1978.

### Changes in Approved Specialties or Subspecialties in Laboratories

L & S Medical Laboratory, 2320 West Lawrence Avenue, Chicago is no longer approved to perform Procedures 510-Blood Group and RH Typing, effective June 1, 1978. The laboratory is still approved to perform Bacteriology, Serology, Routine Chemistry, Clinical Microscopy, Hematology, and Diagnostic Cytology procedures.

Doctors Medical Laboratory, Inc., 11803 South Michigan Avenue, Chicago is no longer approved to perform Procedure 330-Chemistry-Other, Procedure 520-Rh Titers, Procedure 710-EKG Services. These procedures have been deleted effective June 1, 1978. The laboratory is still approved to perform Bacteriology, Parasitology, Serology, Routine Chemistry, Clinical Microscopy, Blood Group and Rh, and Diagnostic Cytology procedures.

*(This report is a service to the physicians of Illinois)*

# Time is the test of all things.



BRIEF SUMMARY

**Indications**: Oral potassium therapy for the prevention and treatment of hypokalemia which may occur secondary to diuretic or corticosteroid administration. May be used in the treatment of cardiac arrhythmias due to digitalis intoxication.

**Contraindications**: Severe renal impairment with oliguria or azotemia, untreated Addison's disease, adynamia episodica hereditaria, acute dehydration, heat cramps and hyperkalemia from any cause.

**Precautions:** Potassium intoxication by oral administration rarely occurs in patients with normal kidney function, however, potassium supplements must be administered with caution, since the amount of the deficiency or daily dosage is not accurately known. Frequent checks of the clinical status of the patient, and periodic ECG and/or serum potassium levels should be made. High serum concentrations of potassium ion may cause death through cardiac depression, arrhythmias or arrest. This drug should be used with caution in the presence of cardiac disease.

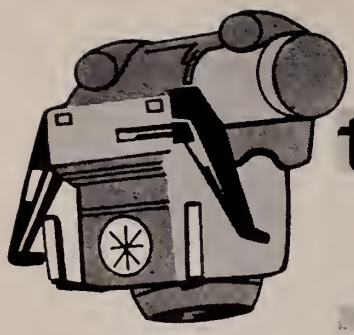
In hypokalemic states, especially in patients on a low-salt diet, hypochloremic alkalosis is a possibility that may require chloride as well as potassium supplementation.

**Adverse Reactions:** Nausea, vomiting, diarrhea, and abdominal discomfort have been reported. The most severe adverse effect is hyperkalemia.

**Overdosage:** Potassium intoxication may result from overdosage of potassium or from therapeutic dosage in conditions stated under "Contraindications". Hyperkalemia, when detected, must be treated immediately because lethal levels can be reached in a few hours.

# Kaon® Elixir
## (potassium gluconate)
20 mEq per 15 ml

**WARREN-TEED**
LABORATORIES, INC.
DIVISION OF **ADRIA LABORATORIES INC.**
COLUMBUS, OHIO 43215



# the view box

Leon Love, M.D./Chairman/Department of Radiology
Loyola University Stritch School of Medicine

*This month's viewbox is submitted by Terrence C. Demos, M.D., Associate Clinical Professor of Radiology, Department of Radiology, Loyola University Medical Center.*

This 52-year-old man had coronary artery bypass surgery one year ago. He now complains of intermittent upper abdominal pain which has been occurring for several months.



**Figure 1A**



**Figure 1B**



**Figure 2**

## *What's Your Diagnosis?*

1. Pericardial cyst
2. Foramen of Morgagni hernia
3. Epicardial fat pad
4. Neoplasm at cardiophrenic angle

*(Continued on page 479)*

Modane® (danthron) LAXATIVE TABLETS

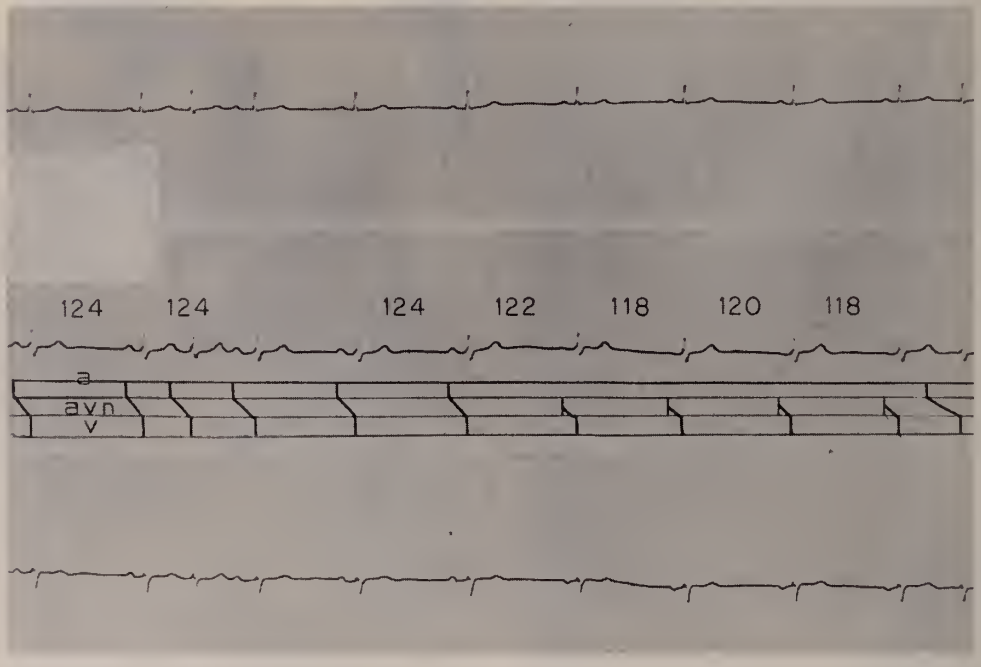
one tablet usually brings gentle, overnight relief

WARREN-TEED LABORATORIES, INC.
DIVISION OF ADRIA LABORATORIES INC.
COLUMBUS, OHIO 43215

# ekg of the month

John F. Moran, M.S., M.D., David L. Fishman, M.D.,
Patrick J. Scanlon, M.D., Sarah A. Johnson, M.D.,
John R. Tobin, M.S., M.D., and Rolf M. Gunnar, M.S., M.D.
Section of Cardiology, Department of Medicine,
Loyola University Stritch School of Medicine

This is a fifty-seven-year-old man who came to his physician with complaints of recent onset hematuria. He also had a vague left flank tenderness and an intermittent low grade fever. His past history was significant for left sided pyelonephritis. The differential diagnosis now was left renal neoplasm, left renal diverticulum, or renal tuberculosis. A renal arteriogram showed a faint blush with a surrounding halo suggesting a lesion in the upper calyx of the left kidney. Cystoscopy with a retrograde pyelogram showed a definite intraluminal neoplastic-appearing lesion in the upper calyx of the left kidney. Surgery was planned. An ECG was taken preoperatively with this simultaneous lead I, II, III rhythm strip.




**Questions:**

1. **The ECG shows:**
   A. Sinus bradycardia.
   B. Ectopic atrial rhythm.
   C. Premature atrial beats.
   D. Evidence of concealed conduction.
   E. All of the above.

2. **Management of this patient should include:**
   A. Cancellation of the proposed surgery.
   B. Placement of a temporary demand pacemaker before surgery.
   C. Prophylactic digitalis.
   D. Careful ECG monitoring.
   E. None of the above.

*(Continued on page 466)*



# Editorials

## An Historic Responsibility

By George T. Wilkins Jr., M.D.
ISMS President, 1977-78

In the early 1920s an ISMS president decried burgeoning government intervention into medical practice. He predicted that: "The time will come when we shall have in Washington a bureaucracy knowing no master. Bureaucracy is a curse wherever inaugurated . . . and in the management of medical affairs it is fatal."

What would be his reaction to today's bloated federal bureaucracy?

Government spending accounts for about 40% of national income . . . and ⅔ of that is spent at the federal level. The U.S. government now spends about $1.26 billion a day . . . or more than $14,000 a second!

Even more alarming is the corresponding rise in the citizenry's dependence upon the federal government. The citizen increasingly looks toward government for the necessities of life—security, management of principal affairs and control of industry. There's not much left for the individual to do for himself.

Nevertheless, there still is hope. The tide seems to be turning toward more common sense and less centralization in government. An increasing number of legislators are back-pedalling on national health insurance after examining the tremendous costs and other drawbacks and questioning the wisdom of state-run medicine.

Another indication of the desire for less government interference is the shrinking influence of labor unions. Several of labor's pet projects suffered crushing defeats in the 1977 Congress. Common sites picketing, oil cargo preference, labor law revision and additional hikes in the minimum wage all went down to defeat. These setbacks are especially significant since labor successfully supported 262 of 365 House candidates and 19 of 28 Senate candidates in the 1976 elections.

There also is evidence that many of the avowed liberals of the 1960's are abandoning their belief that Washington can solve all of our woes. The intellectuals who once wrote about the advantages of socialism have done an about-face because they are seeing what happens when their theories are put to work.

Where America's future is concerned . . . there's bad news and there's good news. The bad news is that government continues to grow. The good news is that traditional big-government types are beginning to realize that government may be part of the problem rather than the solution.

A little more than 200 years ago, a small group of men—five of whom were physicians—sat contemplating the Declaration of Independence. These men believed that government should be the servant of the people—that government which governs least governs best.

These men stood up for their beliefs. It is not too much to ask each of us to do the same. We must learn how to be a minority with the political impact of a majority if we are to accomplish our goal of less government involvement in our personal and professional lives. But we can do this only by becoming more active in the political arena.

Politics is not a spectator sport. To be effective, we must come down out of the stands and involve ourselves in the political process. We must think, talk and act politics, and view our patients not only as patients but as voters.

I urge every physician to do all he can to make government work for its citizens rather than citizens working for the government. We must make this commitment if we expect to retain our professional freedom—the freedom that has enabled us to provide the American public with the best medical care in the world. ◄

# A New Vision of Catapres® (clonidine HCl)

# 20/20



## The first 20 days

- Catapres lowers blood pressure promptly.
- No contraindications.
- Some patients may have dry mouth, drowsiness, and sedation. Tell them that these tend to diminish with continued use.
- Giving the larger part of the divided dose at bedtime can help alleviate drowsiness and sedation.

## The next 20 years*

- Lowered blood pressure.
- Little impotence, depression or postural hypotension.
- No fatal hepatotoxicity in over a decade of worldwide use.
- Broad therapeutic dosage range to keep step with changing dosage needs over the years.

* Tolerance may develop in some patients, necessitating a reevaluation of therapy.

For full details on adverse reactions, warnings and precautions, see brief summary of the prescribing information on last page of this advertisement.



**Catapres®** (clonidine HCl)
**For Step 2 in Hypertension**

HYPERTENSION

# A New Vision of Catapres®
## (clonidine HCl)

Tablets of 0.1 and 0.2 mg




## What you do the first 20 days Can help him the next 20 years

**Catapres®**
**(clonidine hydrochloride)**
Tablets of 0.1 mg and 0.2 mg

**Indication:** The drug is indicated in the treatm hypertension. As an antihypertensive drug, Cat (clonidine hydrochloride) is mild to moderate It may be employed in a general treatment proc with a diuretic and/or other antihypertensive a as needed for proper patient response.

**Warnings:** Tolerance may develop in some pati necessitating a reevaluation of therapy.
*Usage in Pregnancy:* In view of embryotoxic fin animals, and since information on possible adv effects in pregnant women is limited to uncont clinical data, the drug is not recommended in who are or may become pregnant unless the pc benefits outweigh the potential risk to mother
*Usage in Children:* No clinical experience is av with the use of Catapres (clonidine hydrochlor children.

**Precautions:** When discontinuing Catapres (cl hydrochloride), reduce the dose gradually over 4 days to avoid a possible rapid rise in blood p and associated subjective symptoms such as r ness, agitation, and headache. Patients should instructed not to discontinue therapy without c their physician. Rare instances of hypertensive lopathy and death have been recorded after ce of clonidine hydrochloride therapy. A causal re ship has not been established in these cases been demonstrated that an excessive rise in bl sure, should it occur, can be reversed by resum of clonidine hydrochloride therapy or by intravi nous phentolamine. Patients who engage in pc tially hazardous activities, such as operating n or driving, should be advised of the sedative e This drug may enhance the CNS-depressive ef alcohol, barbiturates and other sedatives. Like agent lowering blood pressure, clonidine hydr should be used with caution in patients with se coronary insufficiency, recent myocardial infar cerebrovascular disease or chronic renal failur

As an integral part of their overall long-term patients treated with Catapres (clonidine hydr should receive periodic eye examinations. Whi except for some dryness of the eyes, no drug-abnormal ophthalmologic findings have been with Catapres (clonidine hydrochloride), in se studies the drug produced a dose-dependent in the incidence and severity of spontaneously ring retinal degeneration in albino rats treated 6 months or longer.

**Adverse Reactions:** The most common reactic dry mouth, drowsiness and sedation. Constipa dizziness, headache, and fatigue have been re Generally these effects tend to diminish with c therapy. The following reactions have been as with the drug, some of them rarely. (In some an exact causal relationship has not been esta These include: Anorexia, malaise, nausea, vor parotid pain, mild transient abnormalities in l tion tests; one report of possible drug-induce titis without icterus and hyperbilirubinemia in receiving clonidine hydrochloride, chlorthalid papaverine hydrochloride. Weight gain, transi tion of blood glucose, or serum creatine phos congestive heart failure, Raynaud's phenomer dreams or nightmares, insomnia, other behavi changes, nervousness, restlessness, anxiety a depression. Also rash, angioneurotic edema, l urticaria, thinning of the hair, pruritus not ass with a rash, impotence, urinary retention, incr sensitivity to alcohol, dryness, itching or burn eyes, dryness of the nasal mucosa, pallor, gyn mastia, weakly positive Coombs' test, asympt electrocardiographic abnormalities manifeste Wenckebach period or ventricular trigeminy.

**Overdosage:** Profound hypotension, weaknes lence, diminished or absent reflexes and vom lowed the accidental ingestion of Catapres (c hydrochloride) by several children from 19 mo 5 years of age. Gastric lavage and administra analeptic and vasopressor led to complete rec within 24 hours. Tolazoline in intravenous dos 10 mg at 30-minute intervals usually abolishe fects of Catapres (clonidine hydrochloride) ov

**How Supplied:** Catapres, brand of clonidine h chloride, is available as 0.1 mg (tan) and 0.2 (orange) oval, single-scored tablets in bottles and 1000.

For complete details, please see full prescr information.

Under license from Boehringer Ingelheim (

Boehringer Ingelheim Ltd
Ridgefield, CT. 06877




**"I'm just a shadow of what I used to be."**

That is what depressed individuals may feel is the substance of their being. There is no pleasure, no joy – nothing grows – and in the cold shadow of depression their activities are inhibited, while initiative may be eroded or destroyed. The tragedy is that they can see that others are able to live on the brighter side but they, themselves, cannot reach it on their own.

Your experience in treating depression, and Tofranil-**PM** can help light the way.

Tofranil-**PM**®
imipramine **pamoate**

Geigy

Unsurpassed effectiveness among tricyclics in relieving symptoms of anxious depression.

Before prescribing Tofranil-PM, please review a summary of the prescribing information on the back of this page.

# Tofranil-PM®
## imipramine **pamoate**

Geigy

As anxiety, agitation, sleep disturbances, and other depressive symptoms are relieved, mood and motivation may be markedly improved.

Patients are usually alert and capable of functioning at more normal levels of behavior.

Tofranil-PM encourages patient compliance because one capsule lasts from bedtime to bedtime.

Good results are usually seen at the starting dose of one 75-mg capsule h.s.

For many patients, dosage can be safely increased to 150 mg daily.

As with all tricyclics, sedation may occur. Please caution patients against driving or ope ating dangerous machinery.

Each capsule contains imipramine pamoate equivale to 75, 100, 125 or 150 mg of imipra mine hydrochloride.

**Tofranil-PM®**
**brand of imipramine pamoate**

**Indications.** For the relief of symptoms of depression. Endogenous depression is more likely to be alleviated than other depressive states.

**Contraindications:** The concomitant use of monoamine oxidase inhibiting compounds is contraindicated. Hyperpyretic crises or severe convulsive seizures may occur in patients receiving such combinations. The potentiation of adverse effects can be serious, or even fatal. When it is desired to substitute Tofranil-PM, brand of imipramine pamoate, in patients receiving a monoamine oxidase inhibitor, as long an interval should elapse as the clinical situation will allow, with a minimum of 14 days. Initial dosage should be low and increases should be gradual and cautiously prescribed. The drug is contraindicated during the acute recovery period after a myocardial infarction. Patients with a known hypersensitivity to this compound should not be given the drug. The possibility of cross-sensitivity to other dibenzazepine compounds should be kept in mind.

**Warnings:** *Usage in Pregnancy:* Safe use of imipramine during pregnancy and lactation has not been established; therefore, in administering the drug to pregnant patients, nursing mothers, or women of childbearing potential, the potential benefits must be weighed against the possible hazards. Animal reproduction studies have yielded inconclusive results. There have been clinical reports of congenital malformation associated with the use of this drug, but a causal relationship has not been confirmed.

Extreme caution should be used when this drug is given to:

—patients with cardiovascular disease because of the possibility of conduction defects, arrhythmias, myocardial infarction, strokes and tachycardia;
—patients with increased intraocular pressure, history of urinary retention, or history of narrow-angle glaucoma because of the drug's anticholinergic properties;
—hyperthyroid patients or those on thyroid medication because of the possibility of cardiovascular toxicity;
—patients with a history of seizure disorder because this drug has been shown to lower the seizure threshold;
—patients receiving guanethidine or similar agents since imipramine may block the pharmacologic effects of these drugs.

Since imipramine may impair the mental and/or physical abilities required for the performance of potentially hazardous tasks such as operating an automobile or machinery, the patient should be cautioned accordingly.

*Usage in Children:* Tofranil-PM, brand of imipramine pamoate, should not be used in children of any age because of the increased potential for acute overdosage due to the high unit potency (75 mg., 100 mg., 125 mg. and 150 mg.). Each capsule contains imipramine pamoate equivalent to 75 mg., 100 mg., 125 mg. or 150 mg. imipramine hydrochloride.

**Precautions:** It should be kept in mind that the possibility of suicide in seriously depressed patients is inherent in the illness and may persist until significant remission occurs. Such patients should be carefully supervised during the early phase of treatment with Tofranil-PM, brand of imipramine pamoate, and may require hospitalization. Prescriptions should be written for the smallest amount feasible.

Hypomanic or manic episodes may occur, particularly in patients with cyclic disorders. Such reactions may necessitate discontinuation of the drug. If needed, Tofranil-PM, brand of imipramine pamoate, may be resumed in lower dosage when these episodes are relieved. Administration of a tranquilizer may be useful in controlling such episodes.

Prior to elective surgery, imipramine should be discontinued for as long as the clinical situation will allow.

An activation of the psychosis may occasionally be observed in schizophrenic patients and may require reduction of dosage and the addition of a phenothiazine.

In occasional susceptible patients or in those receiving anticholinergic drugs (including antiparkinsonism agents) in addition, the atropine-like effects may become more pronounced (e.g., paralytic ileus). Close supervision and careful adjustment of dosage is required when this drug is administered concomitantly with anticholinergic or sympathomimetic drugs.

Avoid the use of preparations, such as decongestants and local anesthetics, which contain any sympathomimetic amine (e.g., adrenalin, noradrenalin), since it has been reported that tricyclic antidepressants can potentiate the effects of catecholamines.

Patients should be warned that the concomitant use of alcoholic beverages may be associated with exaggerated effects.

Both elevation and lowering of blood sugar levels have been reported.

Concurrent administration of imipramine with electroshock therapy may increase the hazards; such treatment should be limited to those patients for whom it is essential, since there is limited clinical experience.

**Adverse Reactions:** Note: Although the listing which follows includes a few adverse reactions which have not been reported with this specific drug, the pharmacological similarities among the tricyclic antidepressant drugs require that each of the reactions be considered when imipramine is administered.

*Cardiovascular:* Hypotension, hypertension, tachycardia, palpitation, myocardial infarction, arrhythmias, heart block, stroke, falls.

*Psychiatric:* Confusional states (especially in the elderly) with hallucinations, disorientation, delusions; anxiety, restlessness, agitation; insomnia and nightmares; hypomania, exacerbation of psychosis.

*Neurological:* Numbness, tingling, paresthesias of extremities; incoordination, ataxia, tremors; peripheral neuropathy; extrapyramidal symptoms; seizures, alterations in EEG patterns; tinnitus.

*Anticholinergic:* Dry mouth, and, rarely, associated sublingual adenitis; blurred vision, disturbances of accommodation, mydriasis; constipation, paralytic ileus; urinary retention, delayed micturition, dilation of the urinary tract.

*Allergic:* Skin rash, petechiae, urticaria, itching, photosensitization (avoid excessive exposure to sunlight); edem (general or of face and tongue); drug fever; cross-sensitivity with desipramine.

*Hematologic:* Bone marrow depression including agran ulocytosis; eosinophilia; purpura; thrombocytopenia Leukocyte and differential counts should be performed any patient who develops fever and sore throat during therapy; the drug should be discontinued if there is evidence of pathological neutrophil depression.

*Gastrointestinal:* Nausea and vomiting, anorexia, epiga tric distress, diarrhea; peculiar taste, stomatitis, abdom cramps, black tongue.

*Endocrine:* Gynecomastia in the male; breast enlargement and galactorrhea in the female; increased or decreased libido, impotence; testicular swelling; elevation depression of blood sugar levels.

*Other:* Jaundice (simulating obstructive); altered liver function; weight gain or loss; perspiration; flushing; urinary frequency; drowsiness, dizziness, weakness and fatigue; headache; parotid swelling; alopecia

*Withdrawal Symptoms:* Though not indicative of addict abrupt cessation of treatment after prolonged therapy may produce nausea, headache and malaise.

**Dosage and Administration:** In adult outpatients, therapy should be initiated on a once-a-day basis with mg./day. This may be increased to 150 mg./day which the dose level which usually obtains optimum response necessary, dosage may be increased to 200 mg. day Dosage should be modified as necessary by clinical response and any evidence of intolerance. Daily dosage may be given at bedtime, or in some patients in divided daily doses.

Hospitalized patients should be started on a once-a-da basis with 100-150 mg./day and may be increased to 2 mg./day. Dosage should be increased to 250-300 mg. if there is no response after two weeks.

Following remission, maintenance medication may be quired for a longer period of time at the lowest dose th will maintain remission. The usual adult maintenance dosage is 75-150 mg./day on a once-a-day basis, prefe ably at bedtime.

In adolescent and geriatric patients, capsules of Tofran PM, brand of imipramine pamoate, may be used when total daily dosage is established at 75 mg. or higher It generally unnecessary to exceed 100 mg./day in these patients. This dosage may be given once a day at bedtime or, if needed, in divided daily doses.

**How Supplied:** Tofranil-PM, brand of imipramine pamoate: Capsules of 75, 100, 125 and 150 mg. (Each capsule contains imipramine pamoate equivalent to 75 100, 125 or 150 mg. of imipramine hydrochloride.)
(B) 98-146-840-A(9/75) 667120

**For complete details, including dosage and administration, please refer to the full prescribing informat**

GEIGY Pharmaceuticals
Division of CIBA-GEIGY Corporation
Ardsley, New York 10502

Printed in U.S.A. (10-77) TO 12889

# IMPAC

**ILLINOIS MEDICAL POLITICAL ACTION COMMITTEE**
55 East Monroe Street
Chicago, Illinois 60603
312/782-1963

## *The person who says that he is above politics is really saying that democracy is beneath him.*

This Certainly Isn't You . . . Is It? Join IMPAC Today

---

**IMPAC/AMPAC Membership**
(check one)

- ☐ Sustaining .....$99
- ☐ Family .....$45
- ☐ Regular .....$25
- ☐ Auxiliary .....$20

Return to:

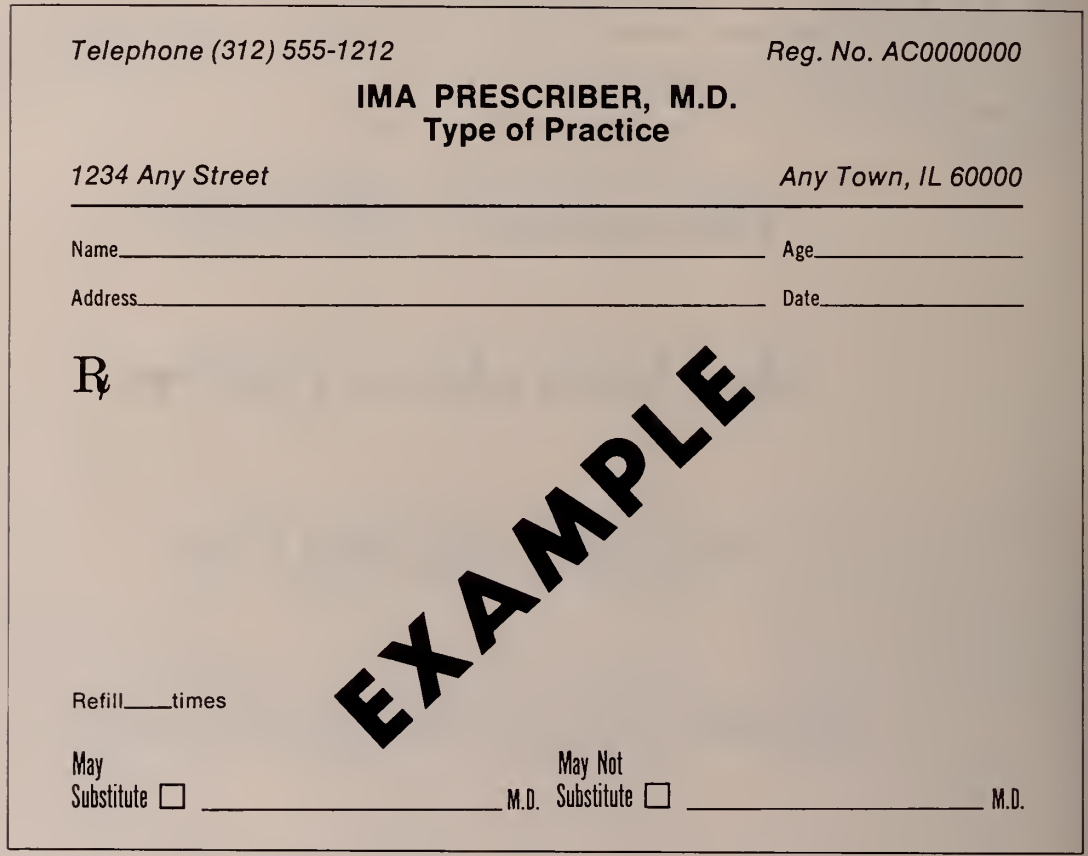
IMPAC
55 E. Monroe Street
Suite 3510
Chicago, Illinois 60630

**NAME** _____ **PHONE** _____

**ADDRESS** _____ **CITY** _____ **ZIP** _____

Contributions are not limited to the suggested amount. Neither the Illinois State Medical Society nor the AMA will favor or disadvantage anyone based upon the amounts of or failure to make pac contributions. Copies of IMPAC & AMPAC reports are filed with and are available for purchase from the Federal Election Commission, Washington, D.C. Contributions are subject to the limitations of FEC regulations, Sections 110.1, 110.2 & 110.5. (Federal regulations require this notice.) IMPAC reports are also filed with the State Board of Elections, and are or will be available for purchase from the State Board of Elections, 1020 South Spring Street, Springfield, Illinois 62704.

# Generic Substitution to be Implemented




On July 1, 1978, the law allowing generic substitution for certain prescribed pharmaceutical preparations will go into effect. Under this law, a pharmacist may substitute an equivalent product, with patient consent, provided: (1) The physician has so indicated on the prescription; and (2) The cost is less than the prescribed item.

Substitution may occur only for those pharmaceuticals listed on a positive formulary developed and distributed by the Illinois Department of Public Health. No other items may be substituted. If a substitution is made, there must be a cost saving and the pharmacist must indicate on the container the name of the manufacturer of the product substituted.

In order for a physician to allow substitution he must check a box and sign the prescription on a line stating "May Substitute." If he checks the box marked "May not substitute" and signs the compatible line, no substitution will occur. However, if one box is checked and the opposite, non-corresponding line is signed, substitution may be accomplished.

The law specifically states that the prescription pad must include a check-off box and signature line for each of the phrases "May Substitute" and "May Not Substitute." While no specific format for a prescription pad has been mandated, printed here is an example of what such may look like, which includes the mandated phrases.

The positive formulary was to have been distributed to all prescribers and dispensers on or about June 1. All comments or questions should be addressed to Dr. Paul Peterson, Director, Department of Public Health, 535 West Jefferson Street, Springfield.


COLACE prevents hard, dry stools common to constipation . . . and does it without laxative stimulation. COLACE assists peristalsis by simply letting intestinal water permeate stools.
COLACE helps to prevent painful straining at stool—particularly important in patients with delicate anorectal disorders. Safe and non-habit forming . . . COLACE, the simple water way to ease constipation from infancy to old age.
Simple drops of water help make COLACE® the most widely used stool softener.
COLACE®
dioctyl sodium sulfosuccinate
Mead Johnson
PHARMACEUTICAL DIVISION




# Does it influence your choice of a peripheral/cerebral vasodilator*?

- Vasodilan—compatible with coexisting diseases
- Vasodilan—compatible with concomitant therapy
- Vasodilan—compatible with your total regimen for vascular insufficiency

***Indications:** Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows:

Possibly Effective:

1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.

Final classification of the less-than-effective indications requires further investigation.

**Composition:** Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg.

Vasodilan injection, isoxsuprine HCl, 5 mg., per ml.

**Dosage and Administration:** Oral: 10 to 20 mg., three or four times daily.

Intramuscular: 5 to 10 mg. (1 or 2 ml.) two or three times daily. Intramuscular administration may be used initially in severe or acute conditions.

**Contraindications and Cautions:** There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

Parenteral administration is not recommended in the presence of hypotension or tachycardia.

Intravenous administration should not be given because of increased likelihood of side effects.

**Adverse Reactions:** On rare occasions oral administration of the drug has been associated in time with the occurrence of hypotension, tachycardia, nausea, vomiting, dizziness, abdominal distress, and severe rash. If rash appears the drug should be discontinued.

Although available evidence suggests a temporal association of these reactions with isoxsuprine, a causal relationship can be neither confirmed nor refuted.

Administration of single dose of 10 mg. intramuscularly may result in hypotension and tachycardia. These symptoms are more pronounced in higher doses. For these reasons single intramuscular doses exceeding 10 mg. are not recommended. Repeated administration of 5 to 10 mg. intramuscularly at suitable intervals may be employed.

**Supplied:** Tablets, 10 mg., bottles of 100, 1000, 5000 and Unit Dose; Tablets, 20 mg., bottles of 100, 500, 1000, 5000 and Unit Dose; Injection, 10 mg. per 2 ml. ampul, box of six 2 ml. ampuls.

U.S. Pat. No. 3,056,836

# VASODILAN®

## (ISOXSUPRINE HCl)

**20-mg tablets**

Mead Johnson PHARMACEUTICAL DIVISION

© 1976 MEAD JOHNSON & COMPANY • EVANSVILLE, INDIANA 47721 U.S.A. MJL7-4269

# *Letters to the Editor*

George T. Wilkins, M.D., President
Illinois State Medical Society

Dear Dr. Wilkins:

The purpose of this letter is to inform you that the Illinois Department of Public Health has been asked by the Center for Disease Control of the Public Health Service to participate in field trials of Wyeth's human diploid cell culture rabies vaccine (WRV). This vaccine has previously been available on a limited basis from CDC for high-risk persons who have exhibited an allergy to duck embryo rabies vaccine or who fail to develop titers following exposure to a high risk animal.

The study will make WRV available for administration to patients exposed to *laboratory confirmed* rabid animals or patients exposed to *high risk wild animals* (skunk, bat, fox) which are not available for examination in a laboratory. Wyeth Laboratories is making this vaccine available for patients in whom treatment can be initiated within 72 hours after exposure and who also receive human rabies immune globulin.

WRV has several advantages over duck embryo rabies vaccine:

1) Five doses instead of 23 are required, given intramuscularly in the deltoid area on days 0, 3, 7, 14, and 28.
2) Each dose of WRV carries approximately the same risk of reaction as 1 dose of DEV, thus reducing the overall risk of reaction when the complete treatment regimens are compared.
3) WRV produces earlier and higher titers than DEV. Human rabies immune globulin in recommended dosage appears to have no significant inhibiting effect on active WRV immunization.

The vaccine is investigational. Therefore, when a physician chooses to use WRV, he must agree to (1) provide the necessary information to the patient (or parent or guardian) and have him or her sign a special consent form provided with the vaccine; (2) collect and submit serum specimens collected on days 0, 7, 14, 28, 42, 90, and 365; (3) provide information on reactions following each dose of WRV.

Physicians can make requests for WRV to local health departments or to the Illinois Department of Public Health, Division of Disease Control (217/782-2016 or 217/782-3300) in Springfield. It is anticipated that several sites over the State will be chosen for storing small amounts of WRV for prompt distribution when a patient has been chosen for inclusion in the study.

Paul Q. Peterson, M.D.
Director of Public Health


**COOK COUNTY**
**Graduate School of Medicine**

CONTINUING EDUCATION COURSES
STARTING DATES—1978

CURRENT CONCEPTS IN MGT. IN COMMON NEOPLASMS, June 12
FLUIDS & ELECTROLYTES, 3 days, June 15
SPECIALTY REVIEW PEDIATRICS, July 10
ADVANCED PERIPHERAL VASCULAR SURGERY, 5 days, July 17
SPECIALTY REVIEW FAMILY PRACTICE, July 17
RADIATION SAFETY IN DIAG. RADIOLOGY, 3 days, July 24
SPECIALTY REVIEW MEDICINE, CERTIFYING, July 30 & August 6
STATE & NAT'L. BD. REV. BASIC, August 6 & CLINICAL, Aug. 14
NEUROLOGY, PART II, CLINICAL, September 11
QUALITY ASSURANCE EVALUATION, 3 days, September 14
SPECIALTY REVIEW ORTHOPAEDICS, August 13
BASIC ELECTROCARDIOGRAPHY, Five days, September 18
EKG. FOR ANESTHESIOLOGISTS, Five days, September 18
SPECIALTY REVIEW DERMATOLOGY, September 25
SEXUAL MEDICINE, Five days, September 25
SPECIALTY REVIEW OBSTETRICS & GYNECOLOGY, September 25
CURRENT TOPICS IN INTERNAL MEDICINE, September 25

*Information concerning numerous other continuation courses available upon request.*

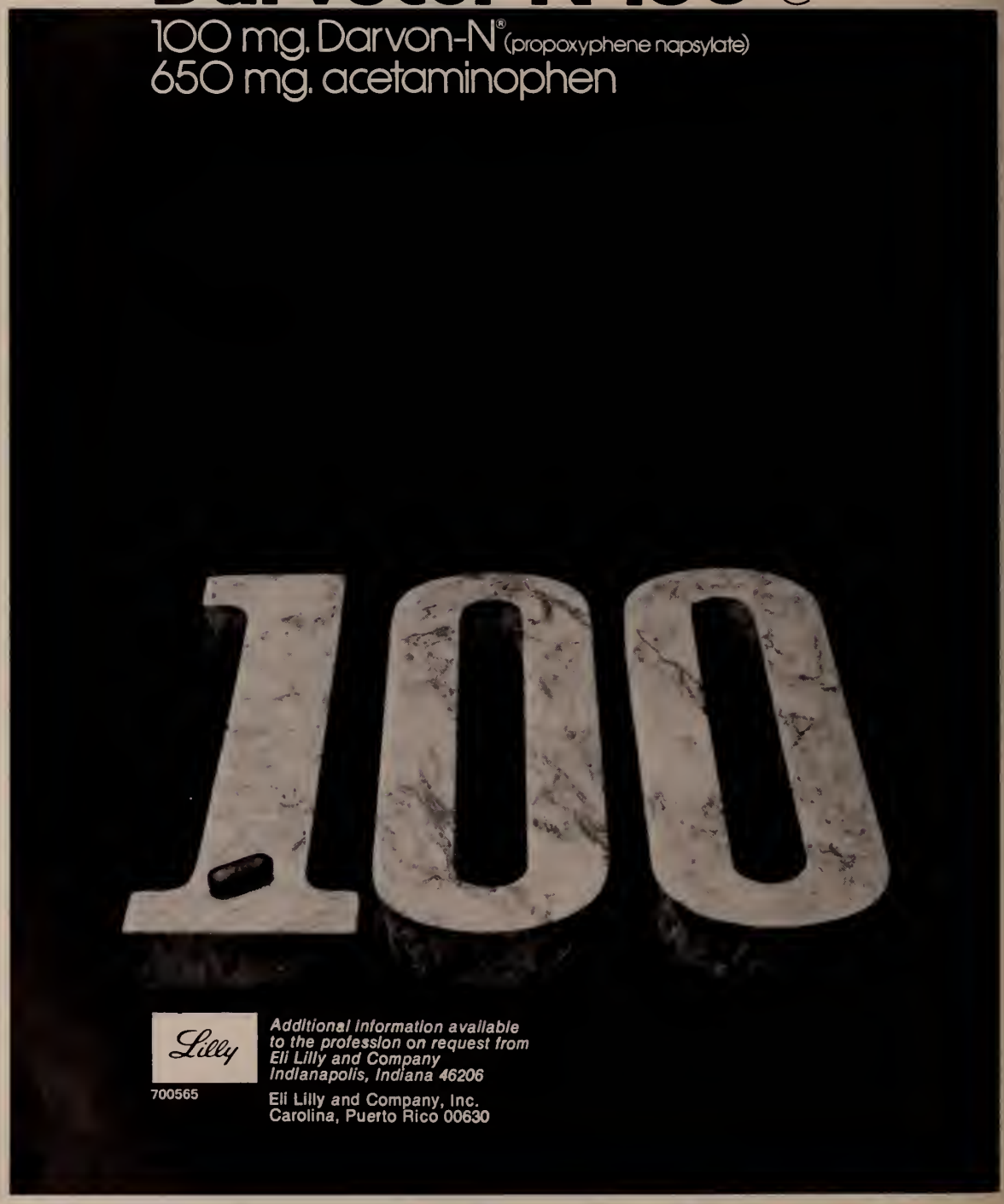
**Address:**
**REGISTRAR, 707 South Wood Street,**
**Chicago, Ill. 60612**

# contains no aspirin

tablets

# Darvocet-N® 100 Ⓒ IV

100 mg. Darvon-N® (propoxyphene napsylate)
650 mg. acetaminophen

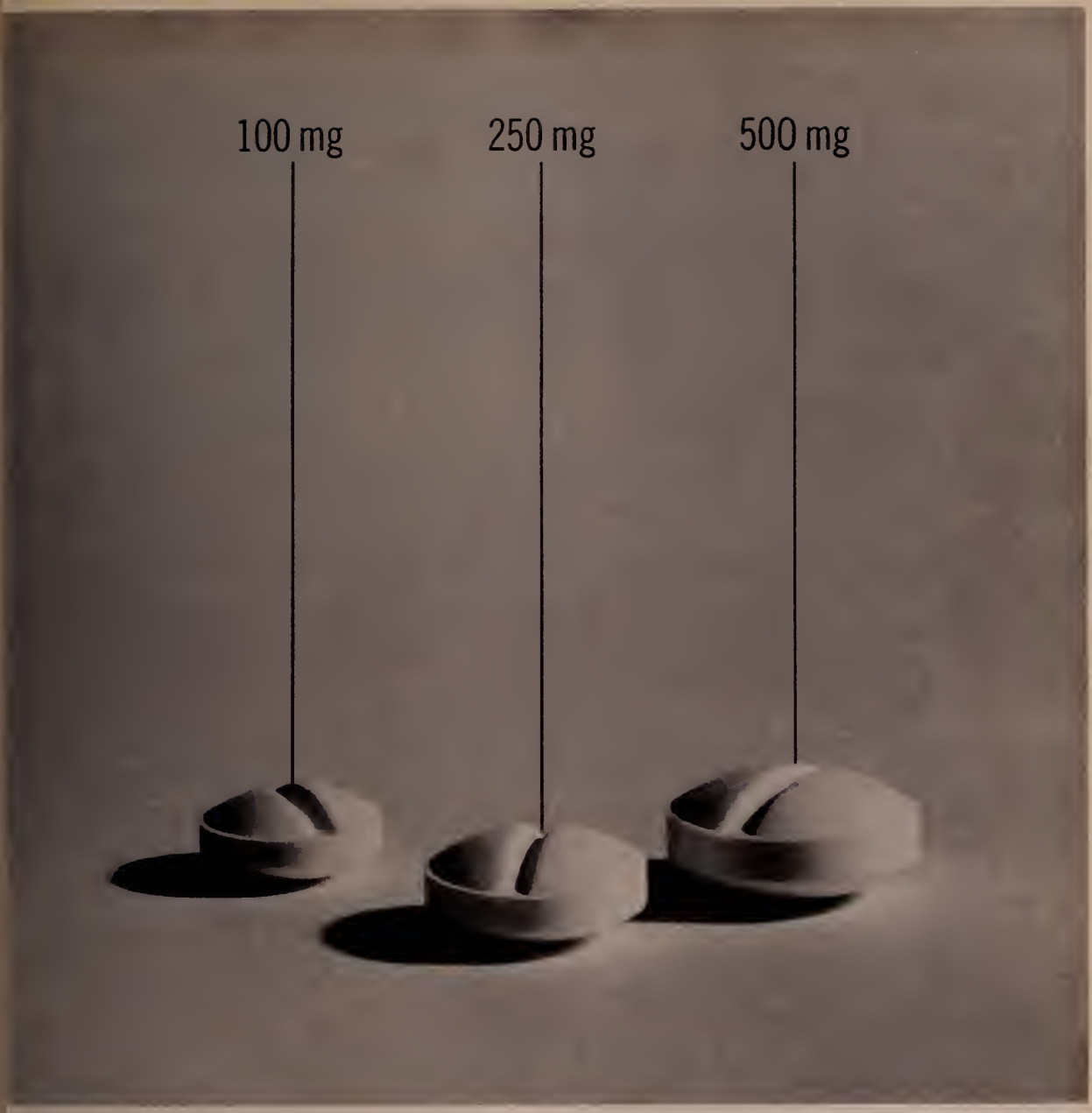



Lilly

*Additional information available to the profession on request from Eli Lilly and Company Indianapolis, Indiana 46206*

700565

Eli Lilly and Company, Inc.
Carolina, Puerto Rico 00630




# Tolinase®
## tolazamide, Upjohn

Please contact your Upjohn representative for additional product information.

Upjohn

J-5695-6

©1977 THE UPJOHN COMPANY




# Highlights of the 1978 ISMS Convention

By Linda L. Hughey, M.D./Wilmette

*This is a monthly column which welcomes contributions, comments, and questions from interested readers. Address all correspondence to Dr. Linda Hughey, c/o the Illinois Medical Journal, 55 E. Monroe, Chicago, Ill. 60603.*

## RPS

The RPS meeting first addressed itself to the subject of officer elections and the following people were elected.

Chairman—Ira Isaacson
Secretary-Editor—Linda Hughey
Delegate—James DeBord
Alternate Delegate—Tony Savino
Vice Chairman/Treasurer—Michael Sadov

In the program which followed, national AMA-RPS president Pat Tokars and Cook County House Staff Association President, Terry Conwall, led a spirited discussion which covered HR2222 (collective bargaining for residents), income tax status of residents and the relevance and efficacy of AMA-RPS and PNHA in furthering resident-member goals. More interaction with PNHA leadership is anticipated in the future.

### AMA—Educational Research Fund

The annual award of the AMA-ERF was made, distributing checks totalling $137,102.13 to 13 branches of the private and public medical schools in Illinois.

### President's Valedictory

ISMS President George T. Wilkins, Jr., commented on the increasing size and complexity of government bureaucracy, pointing out that "today, one in every six Americans works for the government" and that, at present, government spending accounts for 40% of the national income, of which ⅔ is spent at the national level. He called for a return to the tenets of participatory democracy.

President Wilkins also attended the RPS meeting to welcome the residents and to express wholehearted support for Resident participation at all levels of the ISMS.

## Upcoming Events

The 1978 AMA-RPS meeting will be held June 16-17 at the Chase Park Plaza Hotel in St. Louis. The ISMS-RPS is entitled to eleven (11) delegate positions: we anticipate available positions and may be able to supplement funds for residents who cannot get funding from their own hospitals. Please get in touch with Ira Isaacson, chairman of ISMS-RPS, c/o ISMS, 55 East Monroe, Suite 3510, Chicago, Ill. 60603. We hope to see you in St. Louis!

### Follow-up on Physician Disaster Teams

ISMS-RPS received a letter from Robert Hartman, Chairman of the Board of Trustees outlining currently available resources in the state to meet emergency medical needs.

IMJ
Illinois Medical Journal
Vol. 153, No. 6, June, 1978

## A Study of 118 Coroner's Autopsies In Southwest Illinois: 1976-1977

# The Anatomy of Sudden Death

Harry W. Parks, M.D./Collinsville

*In his day-to-day work the forensic pathologist deals with a broad variety of natural and violent deaths. He is constantly reminded and repeatedly impressed with the age-old truth which tells him that although there is only one way in which to be born, there are many ways in which to die.*[1]

The importance of determining the cause, mechanism and manner of death brings into sharp focus the major though not sole function of the coroner's investigating team physician. The nature of this key responsibility indicates that the physician best suited to this assignment is the anatomic pathologist.

The cause of death is the injury or disease responsible for initiating the train of physiological disturbances, brief or prolonged, which produced the fatal termination.

The mechanism of death is the physiologic derangement or biochemical disturbance incompatible with life which is initiated by the cause of death.

The manner of death refers to the fashion in which the cause of death arose.

Thus the cause of death, in a person who died from a bullet's passing through his head, is "gunshot wound of head," the mechanism is "laceration of brain and intracerebral hemorrhage," the manner is "homicide" if the gun was fired by someone else or "suicide" if the victim intentionally pulled the trigger himself.

Of course, determinations are sometimes more

HARRY W. PARKS, M.D., is a pathologist in privote proctice who is boord certified by the Americon Boord of Pothology ond the Americon Board of Nucleor Medicine. Radio-immunology and forensic medicine ore his speciol interests.

complex. For example, consider the young and healthy man who drowns while swimming under the influence of alcohol. Cause: "asphyxia," mechanism: "water inhalation," manner: "alcohol intoxication." But was it "suicidal" or "accidental?" If he was a minor and was sold alcohol illegally, was it "homicide?" Consider the elderly man who dies from a coronary artery occlusion when given a light blow to the cranium in the course of resisting a burglary. Is it "natural causes" or "homicide?" What of the prison inmate who dies from acute intestinal infarction, resulting from volvulus and obstruction at the site of old adhesions. The adhesions were a result of surgical repair for bullet wounds of the bowel, received months earlier, when caught in the act of armed robbery.

Such questions cause the interval between completion of autopsy and final testimony at inquest or trial. The interim period is a time of reflection and consultation for the pathologist: consultation with the bereaved family, the family physician, other members of the coroner's investigating team and attorneys if there is any litigation pending.[2]

These may all be considered preliminary considerations by the pathologist preparatory to his formal appearance at the inquest or trial.

The final responsibility of the pathologist is that of expert witness. He must testify clearly and cooly, but not coldly, as to the cause, mechanism and manner of death to the best of his ability.[3]

The following is an analysis of 118 coroner's autopsies from six counties of southwest Illinois, performed during a twelve month period of 1976 to 1977. The aforementioned roles and criteria were employed in order to form a picture of the anatomy of sudden death in that area. This area was called "Egypt" by its early settlers because of its lush green bottomlands, the great rivers which nourished it, and the mounds left by its Indians.[4]

The earliest beginnings of pathology may be traced to that area's namesake. In the 2600 B.C. Old Kingdom of the pyramid builders this account was found in a tomb painting: "We see the king inspecting a public building with his chief architect, the vizier. As he admires the work and praises his faithful minister, he notices that the latter does not hear the words of royal favour. The king's exclamation alarms the waiting courtiers, the stricken minister is quickly carried to the palace itself, where the Pharoah hastily summons the priests and chief physicians.

"He sends to the library for a case of medical scrolls, but all is in vain. The physicians declare his condition hopeless. The king is smitten with sorrow and retires to his chamber to pray. He then makes all arrangements for the deceased noble's burial, ordering an ebony coffin, and having the body anointed in his own presence. The eldest son of the dead was then empowered to build the tomb, the King furnishing and endowing it."[5]

We can guess, almost with certitude, the identity of the vizier as that of the remarkable physician, priest, writer of proverbs and architect of the pyramid of Saqqarah, Imhotep, whom the Greeks took over as their own god of medicine, calling him Asklepios.[6] On the threshhold of his tomb was the inscription:

*Behold the true physician*
*Lord of life and death.*
*All men, beggar and Pharaoh,*
*Stand naked before him.*

In those days the priestly and healing functions were combined, and a great deal of pathologic anatomy was learned in preparing the dead for mummification.

The body was first eviscerated by means of an incision in the abdomen. The internal organs: heart, liver, lungs, intestines and stomach, were separately mummified and enclosed in four vessels known as canopic jars, each having as a stopper the head of one of the deities known as "the four sons of Horus."[7]

In addition to sudden death from natural causes, a coronary or cerebral vascular accident perhaps, and the numerous casualties of war recorded upon the Pharaoh's victory monuments, there are tomb engravings of the so-called "pessimistic literature" of the New Empire of 1600 B.C.E., for example:[7]

*Death is in my sight today*
*As when a man desires to go home*
*When he has spent many*
*years in captivity*

A suicide note if ever I saw one.
Enough of that other Egypt—what of our own?

**Analysis of Cases**

The 118 autopsies surveyed were divided into groups according to cause of death as follows:

Table 1

| | |
|---|---|
| Gunshot wounds | 24 (20%) |
| Stabbing | 3 ( 3%) |
| Blunt injury | 10 ( 9%) |
| Drug overdose | 6 ( 5%) |
| Asphyxia | 12 (10%) |
| Infection | 12 (10%) |
| Cardiovascular disease | 44 (37%) |
| Neoplasm | 4 ( 3%) |
| Other | 3 ( 3%) |

Of the six counties in which autopsies were performed, two, (St. Clair and Madison) are mainly urban and four, (Randolph, Perry, Jackson and Marion) are mainly rural. The mix of causes of sudden death is a reflection of that fact.

### Gunshot wounds—24 cases

These break down into six categories as follows:

a. Homicides—domestic type, related to arguments between husbands and wives or girl friends. There were four of each sex and in all eight cases the weapon was a hand gun.

b. Homicides—civil type, all related to robbery. All victims were the offenders; three were shot with hand guns kept for self defense and one was shot by the police. The last, and most interesting medicolegal complication, died from intestinal obstruction. The obstruction resulted from adhesions at the site of surgically repaired bullet wounds. The bullets had been fired by police while the victim was committing armed robbery more than a year prior to his death.

c. Homicides—"Execution type" gangland style, three. All black males shot with hand guns, one also with a shot gun, and dumped in another county. One was dredged from the Mississippi river.

Categories "b" and "c" conform to the subtypes of "Criminals Killed Homicide" designated by Wright and Davis.[8]

d. Suicides—seven cases of which five were caucasian males and one black man who committed suicide by a shotgun wound of the abdomen while surrounded by police after a sniping incident. The lone white female used a shotgun to wound her chest while her sleeping male companion, "stoned," never awakened. The five white male suicides all used hand guns to inflict fatal head wounds, two as a result of domestic problems, the other three because of failure to attain "success."

e. Questionable "accidental" suicide—a single case of a young father, baby sitting his small children, who shot himself in the heart in the bedroom with a small calibre gun. He walked through the house before collapsing in the kitchen, where he died.

f. Questionable "self defense" homicide—A combination of categories "a" and "b" where a confrontation of an armed ex-husband with ex-wife and boy friend was resolved by a bystander with a concealed shot gun.

### Stabbing—three cases

These were all healthy males. Two were stabbed through the chest and died of internal hemorrhage. One was treated for his wounds, discharged, and returned to have sutures removed. Some five days after the stabbing he collapsed and died from massive hemorrhage. The cause was an undiagnosed laceration of the spleen, related to the stabbing, which had formed a hematoma that burst.

### Blunt injury—10 cases

These fall into three categories: falls, automobile accidents and bludgeoning.

There were five falls: two male alcoholics fell downstairs and died of subdural hemorrhage, a classical situation. Two elderly females, non-alcoholic, also died from subdural hemorrhage incurred in falls: one down stairs, the other from an X-ray table in a hospital. The fifth was a young female who slipped and fell only three feet striking an automobile bumper and fracturing her liver. The liver showed benign hepatomas or nodular hyperplasia, a lesion associated with use of birth control pills.[9]

Three cases involved the drivers of automobiles: one died from hemorrhage from fractures of liver and spleen, one from multiple rib fractures with bilateral pneumothorax, one from skull fracture and avulsion of brain.

Two bludgeonings were found. One, a newborn infant, the other, a teenage boy, from skull fracture and cerebral edema.

### Drug Overdose—6 cases

These victims were all apparent drug suicides, four young women and two young men—all caucasian. In each case the mechanism was cerebral edema and pulmonary congestion.

Two additional deaths, due to aspiration of gastric contents while intoxicated, were appar-

ently accidental, though drug related, and were classified under asphyxia. A third death occurring from exposure and pneumonia was also drug related but classified as resulting from infection.

**Asphyxia—12 cases**

The largest category was accidental drowning, six cases in all, including five young white males and a middle aged black male. Interestingly, three of these occurred as the direct result of single car auto accidents where the victims were submerged. Two were related to swimming and one to water skiing.

There were three asphyxial deaths related to natural causes; hydrocephalus, epilepsy and asthma.

Two, mentioned previously, were young white males who aspirated gastric contents while intoxicated.

One black adolescent female was strangled with a nylon stocking while baby sitting for her younger sisters.

**Infection—12 cases**

Under this division there were three elderly patients in institutions who died "suddenly" of bacterial bronchopneumonia as a terminal complication of arteriosclerosis and congestive heart failure.

One young white male died of lobar pneumonia and exposure, probably drug related. One young black female died of fulminating purulent pneumonia despite antibiotics. An adolescent caucasian female died of viral myocarditis. A two-day-old premature infant girl died of pneumonia and septicemia, apparently acquired in utero. A middle aged woman died three months after a compound fracture of the leg incurred in a minibike accident, apparently from bacterial sepsis with shock.

There were four infants, (two white males and two black females) aged 3 to 6 months, that expired with findings consistent with Sudden Infant Death Syndrome. This syndrome whether due to some physiologic dysfunction of the central nervous system, viral infection, or other unknown agents, is still a puzzle to the forensic pathologist.[10]

**Cardiovascular Disease—44 cases**

Thirty-six of these were due to coronary artery disease with myocardial infarction; 27 males and 9 females, aged 43 to 84 years.

Four were due to disease of the aorta-stenosis or co-arctation which caused a narrow outflow tract. These were aged 16 to 28, three males and one pregnant female. The last had had successful surgery in childhood for coarctation with insertion of a tefllon graft.

Two were stillborn infants, a white female and a black male, with placental insufficiency.

One was a young female with diffuse pulmonary emboli, probably from deep vein thrombosis: questionably birth control pill related.

One was a 36-year-old black male with acute subarachnoid hemorrhage related to hypertension.

**Neoplasm—4 cases**

Not often thought a cause of sudden death, cancers and even benign neoplasms nevertheless may cause sudden death occasionally. This occurred in 1.7% or 22 cases, of a recent study of 1,300 forensic autopsies.[11] In our series there were four such cases.

One was an elderly man with carcinoma of lung treated with radiation. He expired suddenly by asphyxia when he coughed up and aspirated a large amount of blood.

One was an elderly female who died in acute respiratory failure. She was found to have diffuse tumor emboli of lungs from a primary carcinoma of ovary, undiagnosed. In addition she had large blood clots in both pulmonary and renal arteries—a manifestation of diffuse intravascular coagulation sometimes associated with widespread cancer.

The third case was a young man who ran a fever, became jaundiced, and expired, all within a five day period. Hepatitis was suspected. His autopsy showed nothing grossly, but microscopically his bone marrow was replaced by immature white blood cells consistent with acute leukemia.

The last case was a middle aged woman treated for grand mal epilepsy for several years. She had a seizure at home from which she could not be roused and was D.O.A. at a local hospital. Post-mortem examination found that a well encapsulated tumor in the left temporal lobe of the brain was the cause of her epilepsy. Death resulted during a seizure from rupture of a small cerebral aneurysm with subarachnoid hemorrhage.

**Other—three cases**

One of these was a severely retarded five-year-old male with a rare familial disorder of the central nervous system called "leucodystrophy." He expired in respiratory arrest.

The second was a 39-year-old retarded man who wandered out of a nursing home at night into sub-zero weather clad only in nightclothes and froze to death.

The last was an apparent homicide by incineration, although death by blunt injury or strangulation could not be ruled out. Extreme destructiveness of the fire masked the situation.

**Epidemiological Factors**

The most obvious differences in the incidence of certain causes of sudden death were urban vs. rural, black vs. white, (the two frequently overlapping or coinciding) and male vs. female.

Among gunshot homicides 100% were urban, 80% were black, 66% were males, 50% (all male) were related to criminal activities and 50% to domestic quarrels (equally split between the sexes).

If homicides of all types are considered they are 100% urban, 80% black, 66% male.

Thus the homicide profile is very strongly slanted towards urban, black, males. The predominant age range encompassed youth to early middle age: the years when the pressures are greatest on the individual to "make it."[8]

Suicides by gunshot wound are also 100% urban, 86% white and 86% male. Suicides by all causes are 92% urban, 92% white and 62% males of youth to early middle age. Much the same pressures that impel the high incidence of homicides amongst the urban black population seem to be operating to create a mental state leading to suicide in the urban white population. The more violent means (gunshot homicides) amongst blacks and decreasingly violent means amongst whites (gunshot suicides predominate in males and drug overdoses in females) may represent decreasing levels of pressure or expectations on the part of society in each group. There is also a cultural difference, based on real differences in living standards, which may impel the black to blame and attack society or their family as the cause of "failure" while whites are more likely to blame and attack themselves.

Asphyxial deaths are rather evenly divided between urban and rural locales from all causes but are predominantly seen in males, (90%) of the white race (85%). Predictably, the one homicide by asphyxia was an urban, black female.

Infectious sudden deaths showed no geographic, racial or sex-linked pattern but seemed highly-individual occurrences, most probably individual low resistance.

Cardiovascular disease, at least as it presents to the forensic pathologist, is predominantly (75%) male and white (90%) with no remarkable geographic differences. This is well-correlated with epidemiologic studies of cardiovascular disease carried out among the living.

**Conclusions**

In the past twelve months a six county area of southwest Illinois has provided 118 coroner's autopsies for study by the forensic pathologist. Definite patterns of sudden death have appeared, differing according to urban, rural, racial, sex and age differences in the population study. By sorting the cases out by cause, mechanism and manner of death and applying epidemiologic factors, the anatomy of sudden death in the area under study becomes clearer. The study is ongoing and will be updated as time adds to the total number of cases and as other counties report results. ◄

**References**


1. Adelson, Lester: "The Pathology of Homicide," 1974, Charles C. Thomas.
2. Adelson, Lester: "The Forensic Pathologist," *JAMA*, April 11, 1977. 237:15, p. 1585.
3. Phillips, J. D.: "The Nuts and Bolts" of testfying as a forensic scientist. *Journal of Forensic Sciences*, 22:2, April, 1977, p. 457.
4. Horell, C. William, Piper, Henry Dan, Voigt, John W.: "Land Between the Rivers—The Southern Illinois Country," 1973 Southern Illinois University Press.
5. Breasted, James Henry: "A History of Egypt," 1967 Bantam Books.
6. Hurry, J. B., "Imhotep," Encyclopedia Britannica, 11: 1967.
7. "Egypt" Encyclopedia Britannica, 8: 1967.
8. Wright, R. K., Davis, J. H.: "Studies in the Epidemiology of Murder—A Proposed Classification System." *Journal of Forensic Sciences*, April, 1977, 22:2, p. 464.
9. Murphy, G. P.: "A.C.S. Commission on Cancer Survey Supports Suggested Association between Oral Contraceptive Usage and Liver Tumors," *Bulletin of the American College of Surgeons*, April, 1977.
10. Beckwith, J. B.: "The Sudden Infant Death Syndrome," U.S. Department of Health, Education, and Welfare, 1976.
11. Murphy, Gordon K: "Cancer and the Coroner," *JAMA*, Feb. 21, 1977, 237:8, p. 786.

*Case Report*

# Benign Osteoblastoma

By Robert Kaminski, M.D. and M. Zaitoon, M.D./Berwyn

Benign osteoblastoma, a rare tumor which is vascular and forms osteoid and bone, accounts for less than 1% of all bone tumors.

The ratio of males to females is 2:1. Eighty percent of patients are under 30 years of age. The majority of the lesions were found in the spine or major long bones of lower extremities. The total number of published cases is still less than 200.

## Case Report

T.B., a sixty-year-old white female was first seen in February, 1975, at MacNeal Memorial Hospital. There was a several-month history of pain in the right knee, especially posteriorly. It seemed to be getting gradually more severe. The pain was severe enough to cause a limp. Upon examination there was mild effusion of the right knee with tenderness over its posterior aspect, good stability, and full range of motion. Roentgenograms demonstrated a large osteolytic lesion involving posterior and middle parts of proximal tibia close to articular surface. Junctional zone of reaction was noted, with no soft tissue breakthrough (Figures 1A and 1B). Open biopsy was done and the tissue was interpreted as benign osteoblastoma (Figure 2). A few days later, excision of the tumor by currettage was done, along with replacement with mehtyle merthacrylate bone cement. The patient did well post-operatively and was able to walk without pain. Follow-up X-ray showed no further changes (Figures 3A and 3B).

When last seen in September, 1976, patient



**Figure 1A**
**Anterio-posterior view**

ROBERT S. KAMINSKI, M.D., is an orthopedic surgeon affilioted with MacNeal Memorial Hospital. Doctar Kaminski, chairman of the deportment af surgery at MocNeal, is also a clinical assistant prafessor in the department af arthapedic surgery at the University of Illinois.



MOHAMMED MUNIR ZAITOON, M.D., is a surgical resident in the University af Illinois Division of Uralagy. At this writing, Doctor Zaitoon was o resident at MacNeal Memorial Hospital.



Figure 1B
Large osteolytic lesion in the proximal tibia with junctional zone of reaction (lateral view)



Figure 2
Pathologic section showed diffuse osteoblast (benign osteoblastoma)




Figure 3A
The proximal tibia after curettage and insation of bone cement (anterio-posterior view)




Figure 3B
Lateral view

had no pain or limp, and there was full range of knee motion.

### Comments

Osteoblastoma occurs predominantly in patients less than 20 years old. Seventy-one percent were less than 20 years old and 80% were under 30. The peak incidence, 55%, is in the second decade. The youngest patient was 3 years old and the oldest 63.

Our patient represents the oldest patient that has been reported in the published cases.

Most of the tumors reported were treated either by curettage and bone grafting or resection, if the lesion was located in expendable bone such as a rib or fibula or metacarpal. We used bone cement in this case, because of the patient's age and the lesion's size. In the upper tibia, this kind of treatment is not advised for those in the young age group. ◄

### References


Marsh, Bonfiglio, Brady, Eneking: "Benign Osteoblastoma," *Bone and Joint Journal*, 57-A:1-9, 1975.

Louis Lichtenstein, M. D.: Bone Tumor, (Mosby) Saint Louis, 1972.


## *ISMS Travel Program*

Three of the ISMS travel programs scheduled for 1978 remain open for reservations. These include trips to Imperial Europe (Sept. 2-12); the Eastern Mediterranean Air/Sea Cruise (Oct. 25-Nov. 7) and the West Indies Christmas Cruise, (Dec. 19-27). The first trip of 1979 will be an African Adventure in late February.

Descriptive brochures will be mailed five months in advance. Reservations cannot be accepted without the official form printed in these brochures. Individuals outside a member's immediate family will be placed on standby status until all ISMS members have had reasonable time to make reservations. *Promotional expenses connected with these programs are paid for by the tour operator.* For further information, contact ISMS headquarters.




# Tired of the Rat Race?

Tired of the crime, the congestion, the tension and frustration of the big city and the big city hospital? Are you running your life or is your life running you?

If the "good life" is eluding you, in your present location, Steuben County in Indiana is worthy of your consideration, as a place to practice medicine and to live.

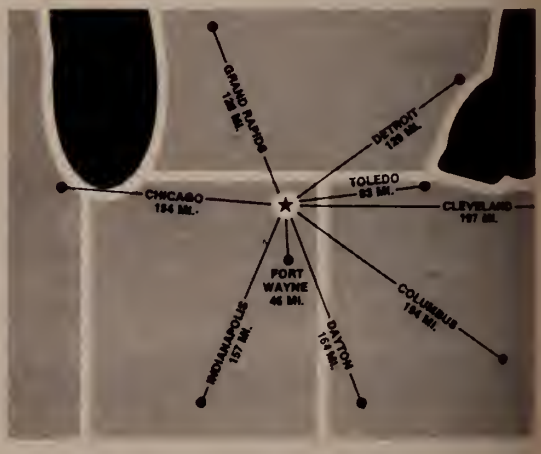
Located in the northeast corner of Indiana, with a population of 22,000, it has a stable economy based on agriculture, light industry and tourism.

Steuben County is endowed with 116 lakes which attract an additional summer population of 100,000 for fishing, other water sports, and general vacationing.

A new, first rate 60 bed hospital is just being completed, with ICU/CCU unit, 24 hour E.R. physician coverage, and facilities for radiographic special procedures, providing an uncomplicated setting in which to practice quality medicine.

This area has 45 minute access to sophisticated medical center and the larger city advantages of Fort Wayne; 3 hour freeway access to Chicago.

It has many friendly communities, where you can enjoy living and raising a family, which need and want the services of both family practitioners and specialists.




For more information, contact Wendell Jacob, Chairman Physician Recruitment Committee, 15 South Public Square, Angola, Indiana. 46703. (219) 665-3194.




# Seminars In Immunopathology and Oncology

Richard J. Ablin, Ph.D., Contributing Editor


# Complement Updated for the Clinician


By D. G. Palmer, M.D./New Zealand



*The estimation of complement in serum and other body fluids, particularly synovial fluid, now has an established place in the assessment, prognosis and response to treatment of diseases associated with immunological phenomena. The complement sequence itself, the factors which may affect the concentration of the various components and the altered patterns which characterize various disease processes are reviewed.*


The fact that a serum factor, additional to antibody was involved in immune mechanisms, became apparent during the last decade of the nineteenth century. Buchner[1] found that if immune serum was heated (55°C for half an hour) the cell lytic effect produced by untreated fresh serum was lost. Bordet[2] further demonstrated that the bactericidal effect of immune serum, lost after either prolonged standing or heating, could be restored by the addition of a small volume of normal serum. This factor, originally referred to as "alexin," (Greek: to ward off) later became known as "complement" (Latin: that which completes). (References to the early literature concerning complement are to be found in the text "Complement or Alexin," T. W. B. Osborn: Oxford University Press, London: Humphrey Milford 1937.)

Complement activation is now a recognized factor of major importance in the pathogenesis of various connective tissue and renal diseases. This role may be added to its long-established part in antibody mediated haemolysis and defense mechanisms against micro-organisms. Much interest has been stimulated recently by descriptions of genetically determined disorders in which absence of a complement component may be associated with a disease syndrome. Estimation of whole complement and of selected individual components now has an established place in the diagnosis, prognosis and assessment of response to therapy in these disorders. This




DAVID G. PALMER, M.D., is an associate professor in medicine who heads the Rheumatic Diseases Research Unit at the Wellcome Medical Research Institute, University of Otago Medical School and the Rheumatic Diseases Service to the Otago Hospitol Board, Dunedin, New Zealond. He is a Fellow of the Royal Australasian College of Physicians and is currently President of the New Zealand Rheumatism Association.

review is an appreciation of these developments.

The detection of complement in serum and the investigation of its physical characteristics, such as inactivation by storage and by heat, initially depended upon tests of haemolytic function. Similarly, the early attempts to fractionate complement depended upon the selective inactivation of one or other component by chemical or physical means. Restoration of haemolytic activity to standard sera (which had been depleted of one or other such component) was used to quantitate the concentration of the same component in sera under test. In the course of time four components came to be recognized: C′1, C′2, C′3 and C′4. When the sequential nature of the "complement cascade" was studied in greater detail, however, this order was revised to C′1, C′4, C′2 and C′3 and additional components were later recognized. This revision in sequential order accounts for references to the C42* complex rather than to the expected numerical order.

Advances in biochemical technology, including column chromatography, electrophoresis and ultracentrifugation, have led to further characterizations of the individual complement components. Nine specific proteins, all globulins, form the framework of the principal complement sequence. In addition, the components of the alternative pathway (vide, *infra*) have become relatively well defined. The interactions of these proteins which lead to functional effects, are either enzymatic or molecular aggregative in nature. Divalent cations ($Mg^{2+}$; $Ca^{2+}$) are required in some of these interactions. Purification of the individual complement proteins has permitted preparation of specific antibodies and these are now used for both quantitative assay by radial immunodiffusion[3] and histological localization of complement components bound to antigen-antibody complexes in tissue sections.

These defined complement components are designated by number (C1-C9). A bar over the component number (asterisk in this text) indicates the activated state capable of enzymatic activity and fragments resulting from cleavage reactions are indicated by lower case letters. The symbol C rather than C′ to designate complement is now in common use.[4] Alternative pathway components are now similarly designated by capital letters and cleavage products produced during activation of this pathway are likewise noted by small letters.

This account will not attempt to appraise the relatively fragmentary knowledge concerning the precise control mechanisms of complement activation which must be exceedingly complex. Inhibitors of various steps are known to exist, however, and the biological activity of some of the products generated is very transient—a controlling factor in itself. A review of considerable breadth and detail has been published.[5] The intricate details of complement activation should not be allowed to obscure the basic fact that activation is a defense mechanism which leads to bacterial destruction.

## Complement Activation

An appreciation of the mechanisms able to initiate the complement activation sequence is essential to an understanding of those diseases characterized by complement consumption. Depending upon the nature of the initial stimulus, the "classic" or the "alternative" initiation pathway is triggered. This leads in both cases to the production of active C3 (C3* or more properly C3b). C3b, the common product of these two pathways initiates the terminal sequence, which on completion results in lysis of the cell or destruction of the immune complex upon which the complement sequence has been assembled.

## The Classic Pathway (First Stage)

The classic pathway for complement activation may be considered to consist of two stages. In the first stage the three components C1, C4 and C2 interact in that order to produce activated C3 (Figure 1). The second stage, called the terminal sequence, is completed by the sequential activation of the five components C5-C9.

The first component C1 will dissociate in the absence of calcium, into three subunits C1q, C1r, C1s.[6] These subunits are of more than biochemical interest. They are individually synthesized. Genetically determined deficiencies of each in isolation have been recognized. When complement is activated, these subunits are usually consumed in parallel from the fluid phase.[7] C1q has been shown to be the component which actually binds to antibody after the formation of antigen-antibody complexes.[8] It thus plays a unique role

*The asterisk indicates the activated state of the molecule. (Standard World Health Organization Nomenclature is a bar over the molecular symbol as shown in the figures herein. Because reproduction of this nomenclature in the text was not feasible, the bar is herein represented by an asterisk.)*

Fig. 1. The Classic Pathway

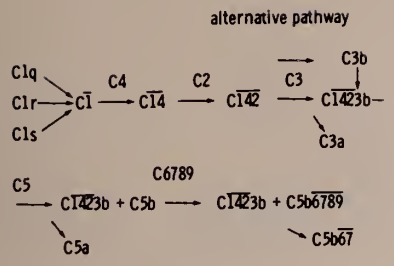



**Figure 1**

**Cleavage products C3a C3b, C5a C5b are active cleavage products and thus need not be designated by a bar. C6789 are also assembled in numerical sequence.**

in determining that complement activation should proceed. C1r forms a link between C1s and C1q and once this initial assembly has been completed C1s is so altered as to function as an esterase with C4 and C2 as substrates.

Primary deficiencies of the subunits C1r and C1s associated with systemic lupus erythematosus-like states have been described[9-11] and C1q deficiency has been associated with an immunologic deficiency syndrome.[12] In such patients total haemolytic activity will be deficient. However, other components, (apart from the single absent component) which would be concurrently depressed in lupus erythematosus itself, will be found normal. Thus loss of complement activity is not due to the consumption of components resulting from the disease, but is due to a failure in function of the pathway itself.

An important inhibitor of the esterase activity residing in C1s is present in normal serum. In hereditary angioneurotic oedema this inhibitor of C1 esterase is deficient. During attacks of that disorder, the substrates of C1*, C4 and C2 are consumed and may become undetectable.[13] A polypeptide (which may be derived from C2)[14] is produced by this interaction and causes the increase in vascular permeability characteristic of the disease.[15] The condition has been successfully treated with fresh frozen plasma which presumably supplies the C1 esterase inhibitor,[16] and attacks can be prevented by E-aminocaproic acid which is an inhibitor of plasminogen. The later observation suggests that attacks may be precipitated through intermittent activity of the clotting mechanism. It is also exceedingly interesting that depletion of these early complement components has also been associated with a lupus-like syndrome complicating hereditary angioneurotic oedema.[17]

The substrates of C1*, that is C4 and C2, can be considered together. It is of some interest that even in the absence of C1* esterase, C4 and C2 can form a reversible complex,[18] which is converted into a stable compound through the enzymatic activity of C1*. C4 is in fact converted by C1* into a form which then renders C2 susceptible to C1* activity.[19] C42*, the complex which results, is a peptidase which cleaves C3 (and can thus be referred to as a C3 convertase) into two fragments C3a and C3b. It is the latter which initiates the terminal sequence. Primary deficiencies of both C4 and C2 have been described which have again been associated with lupus-like states similar to those of C1 subunit deficiencies.[20-22] The mechanisms by which deficiencies of these classic pathway components lead to a lupus-like state is open to conjecture. One possibility is that immune complexes are not effectively cleared from the circulation as a result of the deficiency and another, that an infectious agent might be free to proliferate. LE cells and anti-nuclear factors may or may not be present in these syndromes.

Depletion of C1, C4 and C2 from serum and other body fluids occurs during the course of classic pathway activation by sensitized cells and immune complexes. Estimations of C1q and of C4 are commonly used as a profile of this activity and depletion is thus the hallmark of immune-mediated complement activation.

## The Alternative Pathway

The alternative pathway is a mechanism for activation of C3 and the terminal sequence (C5-C9) independent of the initial part of the classic pathway in which C3 is activated through C42* (vide, *supra*). This pathway provides a defense mechanism against bacteria which is not dependent upon the presence of specific antibody. This alternative pathway was described by Pillemer *et al.*,[23] who demonstrated its existence by exploiting the properties of zymosan, a substance previously known to deplete serum of C3. (Zymosan is a trypsin digested, water and alcohol extracted, preparation of yeast cells.) This property was found to be due to a serum factor which was activated when absorbed onto the zymosan and which came to be known as properdin (Latin; perdere = to destroy). It was then discovered that serum could be depleted of

Figure 2. The alternative pathway

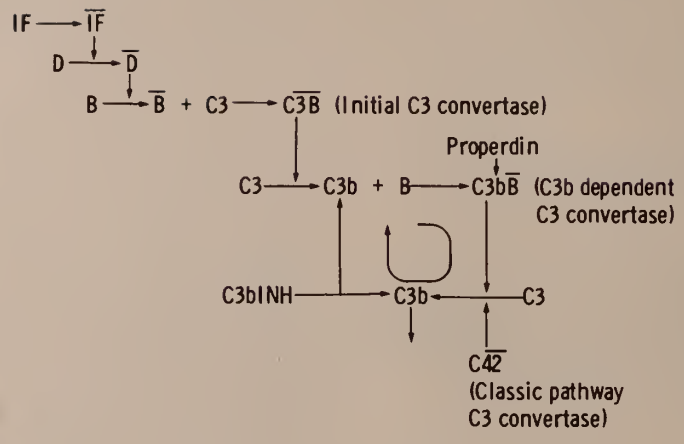



**Figure 2**

**Note that C3b is essential for the continued production of further C3b by the alternative pathway. This sequence may be initiated either by C3bB* from the alternative pathway or C42* from the classic pathway. Once underway, however, C3b production is controlled by C3bINH.**

**Alternative terminology**

| Current** | Functional | Descriptive |
|---|---|---|
| I.F. | Initiating factor | 7S pseudoglobulin |
| D | C3 proactivator convertase | Pro-glycine-rich β-glycoproteinase (GBG-ase) |
| B | C3 proactivator | Glycine-rich β-glycoprotein (GBG) |
| B* | C3b-dependent C3 convertase | Glycine-rich Y-glycoprotein (GBG) |
| P | — | Properdin |
| C3bINH | C3b Inhibitor | — |

**Second International Congress of Immunology, Brighton, United Kingdom.

this factor properdin by absorption onto zymosan (with subsequent removal) at a temperature below that which would ordinarily lead to complement activation. Serum treated in this way retained complement activity in response to classic pathway activation, but further fresh zymosan was no longer effective as a complement activator. A factor essential to the function of the alternative pathway had been removed. Non-immunological mechanisms which may directly activate the alternative pathway include polysaccharides (zymosan, inulin and bacterial endotoxin). Cobra venom factor which has recently been shown to be cobra C3b[24] acts similarly and induces complement-mediated haemolysis.[25] It has become apparent that some immunologic mechanisms, such as aggregated IgA, may also activate complement through the alternative pathway.[26] Recent advances in understanding of the alternative pathway will probably lead very shortly to a full exposé of its components and role.[27,28]

The essential steps of the alternative pathway (Figure 2) seem to be the activation of an initiating factor (I.F.) by a suitable stimulus, followed by sequential activation of components B through D to form an enzyme which acts as an initial C3 convertase. This C3 convertase is dependent upon native C3 itself for activity, and can be designated C3B* in its active form. P (the original properdin) acts to stabilize this enzyme. Once C3b has been formed, C3 conversion to C3b and C3a proceeds, and a second C3 convertase is generated from B with C3b the ancil-

**Table 1**

Components which are commonly estimated in the differentiation of the classic and alternative pathways

| Classic pathway | | Alternative pathway |
|---|---|---|
| C1q | reduced | unaffected |
| C4 | reduced | unaffected |
| P | unaffected or reduced | reduced |
| B | unaffected or reduced | reduced |
| $Ca^{2+}$ | dependent* | independent |
| $Mg^{2+}$ | dependent* | dependent |

*The dependence upon these cations can be tested by effect of EDTA (chelates $Ca^{2+}$ and $Mg^{2+}$) which blocks both pathways and by $Mg^{2+}$ EGTA (chelates $Ca^{2+}$ only) which blocks only the classic pathway.

lary component. The essential presence of C3b provides an autocatalytic amplification mechanism for its own production-under the control of a C3b inhibitor (C3bINH). It will be appreciated that C3b, produced by the classic pathway, may thus lead to alternative pathway activity.[29]

A disorder in which C3b inactivator was absent has been described. Uncontrolled complement depletion was associated with recurrent infections and urticaria.[30,31] As disorders which lead primarily to the consumption of complement through classic pathway activation may deplete alternative pathway components through C3b feedback, it can be difficult to determine the primary mechanism. A potentially very important role played by the alternative pathway has recently been described. Immune complexes break up when incubated with fresh serum at 37°C and this is dependent upon C3b generation by the alternative pathway and incorporation into the immune complex.[32] An active alternative pathway may be of importance in clearing immune complex deposits from such organs as the kidney.

Table 1 lists those factors which are commonly assayed in attempting to characterize the primary pathway of complement activation.

## The Terminal Sequence

It has been noted that activation of the first stage in both the classic and the alternative pathways lead to activation of the terminal sequence, (C5-C9) through the formation of C3b (Figure 1). This sequence is associated with the release of pharmacologically active products and destruction of the cell, bacterium or immune complex onto which complement has been absorbed. After C3 has been split enzymatically by C142* a smaller fragment C3a appears which has anaphylatoxic properties—that is, it is capable of releasing histamine from mast cells. The larger fragment, C3b, becomes bound to immune complexes or antibody coated cells, in association with C1, 4 and 2. The important role of C3b in the feedback mechanism, by which further C3 is activated through the alternative pathway, has been discussed.

When purified and injected intradermally, C3a produces a wheal with venular damage and degranulation of mast cells, but without the accumulation of leukocytes.[33] The wheal may be inhibited in part by an antihistamine. Because polymorphonuclear leukocytes and monocytes bear C3b receptors, "immune adherence" to C3b bearing particles is seen and phagocytosis is enhanced.[34] In addition it has recently been shown that both C3b (through exocytosis) and C3a (because of cell death) produce release of a C3 convertase from cultured mouse macrophages. It may well be that this mechanism—which is self amplifying—may be an important factor in chronic inflammation (Figure 3).[35] Primary deficiency of C3 has been associated with repeated infections very similar to the susceptibility to infection resulting from agammaglobulinaemia. The importance of C3 in host resistance to infection can be related both to the loss of multiple functions of C3 cleavage products—immune adherence, enhancement of phagocytosis and anaphylatoxin generation—and to a failure in

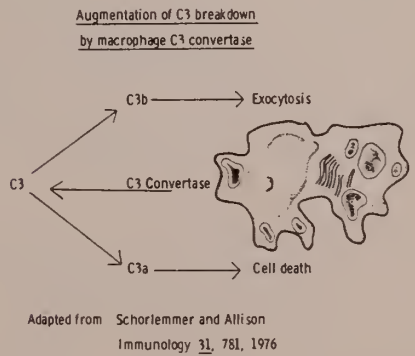



**Figure 3**

**Augmentation of C3b production by the action of C3b and C3a on macrophages. Schorlemmer-Allison concept.**

the formation of active products in the later steps of the complement sequence.[36]

C3b bound in association with C142* becomes an active protease[37] which has C5 as a substrate. C5 is split into two fragments—a smaller C5a and a larger C5b. C5a has similar anaphylatoxic and opsonic properties to C3a and in addition is chemotactic.[38] Defective opsonic activity has been noted in patients with primary C5 deficiency.[39]

C5b is concerned with the assembly of the remaining terminal sequence. Müller-Eberhard and associates[40,41] have described a multi-molecular complex of C5b-C9 which could be recovered as a by-product of immune cytolysis. The assembly of this complex was found to be of a non-enzymatic physico-chemical nature. It did not contain C3b*. It had a molecular weight of approximately 1 x $10^6$ and contained one molecule each of C5b, C6, C7 and C8, together with 6 binding sites for C9. It was of interest that the electrophoretic mobility of the complex as a whole was the same as that of C9 which suggested that this component coated the surface of the complex. C5b67*, which is generated during the formation of C5-9, is chemotactic[42] and has the property of binding to unsensitized cells and allowing lysis to occur in the presence of C8 and C9.[43] Normally this sequel is under the control of a C5b67* inhibitor. Non-immune cell lysis of this nature, which is referred to as "reactive lysis," occurs in paroxysmal nocturnal haemoglobinuria[44] in which condition both the red cells and platelets[45] are very sensitive to the lytic action of complement. Primary deficiencies of C5, C6 and C7 have been described.[46-48] C5 deficiency is associated with susceptibility to infection in infancy and C6 and 7 with defects in those functions that require completion of the total sequence. Bactericidal activity and haemolytic activity have been found lacking but the biological activities associated with the earlier components, opsonisation, immune adherence and chemotactic activity have been intact.

The estimation of total haemolytic activity is used as a screen to indicate deficiency or consumption of any component upon which this final function is dependent. Total haemolytic complement, CH50, is defined as the reciprocal of the dilution of serum yielding 50% lysis of sensitized erythrocytes. The morphological changes which accompany the damage to sensitized red cells on completion of the full complement sequence have been shown by electron microscopy to consist of randomly arranged holes 80-100 A in diameter.[49] Similar lesions have been demonstrated in the walls of sensitized bacteria exposed to complement.

## Complement Depletion

Complement is not normally depressed and may be raised during intercurrent infections.[50] This is because certain components act as acute phase reactants (C3 and C4 particularly). In various diseases, however, particularly connective tissue, renal and blood diseases, complement fixation to antibody-antigen complexes may occur. This contributes to a fall in both total haemolytic complement, and in levels of the individual components. In general, the earlier components are affected to a greater degree than the later. Various patterns can be rather characteristic of particular diseases. The absolute values of these complement components, however, depend not only on the rate of consumption; but also on their rate of synthesis and replacement. Thus a normal complement level does not exclude consumption. Depressed synthesis, rather than accelerated consumption, has been found responsible for falls in complement components, including C3.[51] It has been possible to overcome this limitation in interpretation under some circumstances, by estimating either the rate of component consumption or the level of breakdown products, both of which may be increased when the serum level of the component is normal.[52]

## Abnormalities

The primary purpose of this review has been to assist the physician in appreciating current literature concerning complement. The abnormalities of complement which may be associated with disease will be considered in bare outline only. It should be appreciated that workers describing changes in complement components are restricted to those components for which they have had specific anti-sera or other means for quantitation available. This in itself can lead to difficulties in comparing results from different centres. It is common to read that a particular complement component has been found reduced as the only change when in fact, the levels of other components have not been estimated.

A minimal screen in the clinical situation consists of an estimate to total haemolytic complement (CH50) and if this proves to be reduced it could ordinarily be confirmed by finding a concurrent depletion of C3. A reduction in C4 (and if available C1q) would implicate the classic

pathway, whereas normal levels would indicate complement activation via the alternative pathway. A reduction in P or B would confirm this supposition.

Apparent consumption of complement (CH50 reduced) with normal levels of available individual components would suggest a defect in the sequence and the possibility of some other component's congenital absence. A full screen of all components undertaken in a laboratory with a special interest could confirm such a suspicion.

In some disorders associated with classic pathway activity a good correlation has been found between the depressed levels of C4 and C3. Again, however, accelerated consumption of C3, through activation of the C3bB* feedback and the alternative pathway can lead to apparently anomalous results. This mechanism can lead to prolonged depression of C3 despite C4 having returned to normal. Such possibilities may also cause serious difficulties in correctly interpreting the nature and significance of changes in complement levels.

Alterations of complement in the haemolytic anaemias have been reviewed[53] and changes with allograft rejection described.[54]

Several renal disorders are associated with abnormalities of complement. In lupus nephritis and usually in acute glomerulonephritis, C3 is reduced along with total haemolytic complement, with evidence that this is primarily mediated through the classic pathway (C1q and C4 reduced). This would be expected, as these diseases are associated with immune complex formation. In both conditions, however, as a result of C3bB* feedback, the alternative pathway is also active. In acute glomerulonephritis this secondary mechanism has been held responsible for the persistent depression of C3 after recovery of the C4 has heralded an end to classic pathway activity and the beginning of recovery. Usually, however, C4 is a more sensitive index of disease activity and a fall precedes that of C3 and remains longer depressed. It is worthy of note that no change in complement levels were found in the Henoch-Schonlein syndrome, Goodpasture's syndrome or chronic glomerulonephritis.[55] In mesangiocapillary glomerulonephritis a further factor depleting complement has been described. This is the "C3 nephritic factor" which operates through the alternative pathway.[56] In patients with bacterial endocarditis complicated by focal embolic or acute diffuse nephritis a diagnostically significant fall in total complement may occur.[57]

Complement consumption occurs in several connective tissue disorders. Note has already been made of complement consumption in the presence of lupus nephritis. Depression of complement in this disease is usually, but not exclusively, found in those patients with nephritis. When a fall in complement levels is detected by serial estimations this has been shown to indicate that a relapse is likely and will probably be associated with renal deterioration.[58] In rheumatoid arthritis complement levels in both serum and synovial fluid have been studied. In the serum, the likelihood of the C3 level being depressed increases if rheumatoid factor is present and more particularly if there is a vasculitis.[59] Normal levels of C3 in the presence of a rheumatoid vasculitis do not exclude increased complement consumption which had been compensated by increased component synthesis.[60] In the synovial fluid several groups have confirmed the initial report of Zvaifler and Pekin[61] that complement is depressed—a finding which suggests consumption by the immune complexes generated within joints involved by this disease. Of much interest is the observation that a polyarthritis may precede the icteric stage of hepatitis associated with Australian antigen. This appears to be related to the consumption of complement in synovial fluid containing the antigen-antibody complexes.[62] Although such cases are themselves uncommon, this observation strengthens the case for antigen-antibody reactions with consumption of complement, being of importance in the genesis of some forms of arthritis.

Finally attention must be drawn to a further developing aspect of the complement saga. Some of the complement components have gene expression in the histocompatibility complex (chromosome 6). Furthermore genetically determined polymorphism of C3 has been described.[63] It may yet be proven that disease susceptibility may have a subtle relationship not only to defective or absent complement components, but also to allotypic variations, associations with tissue antigens and with immune response genes. ◄

**Acknowledgement**

The financial support of the Medical Research Council of New Zealand is gratefully acknowledged.

**References**

A complete list of references for "Complement Updated for the Clinician," may be obtained by writing the Illinois Medical Journal, 55 E. Monroe, Suite 3510, Chicago 60603.




Edited By John M. Beal, M.D.

*Surgical Grand Rounds are held weekly on Tuesday at 5:00 p.m. in the Offield Auditorium of the Passavant Pavilion of Northwestern Memorial Hospital. Patient presentations from Northwestern Memorial Hospital and the Veterans Administration Lakeside Hospital form the basis of the discussions. This case report was part of the Surgical Grand Rounds of September 13, 1977.*

# Gun Shot Wound to the Neck

**Dr. James Wolf:** Today we shall consider penetrating trauma of the neck, a topic chosen for two reasons. One is to review the surgical anatomy of the neck, and second, the management of penetrating wounds of the neck.

**Dr. Wilson Hartz, III:** A 23-year-old white man was seen in the Emergency Room of the Northwestern Memorial Hospital five hours following a gun shot wound to the neck. He had been shot from a distance of about five feet, noticed pain in both arms and then staggered backwards and collapsed. He did not lose consciousness, report difficulty breathing, or demonstrate evidence of external blood loss. An episode of hemoptysis occurred just prior to admission. He was greatly concerned about paralysis of his left arm and leg. He was able to talk well and was breathing normally upon arrival in the Emergency room. Vital signs were normal and stable; the neck was slightly swollen with diffuse crepitus. An anterior entrance wound was found just below the thyroid cartilage, to the left of the midline and an exit wound in the posterior neck, three centimeters to the left of the midline. He had paralysis in the left arm and leg that was consistent with a motor deficit at the level of C-6. On the right side, he had a sensory deficit two levels below, consistent with a Brown-Sequard at the level of C-6.

Intravenous fluid was administered and a Foley catheter inserted. A chest X-ray revealed subcutaneous emphysema in the neck. Pneumo- or hemothorax were not present. The cervical spine film showed a chip fracture of C-6.

After initial evaluation, he was taken to the operating room and given endotracheal general anesthesia. After the intubation, blood was detected within the trachea on suctioning. A left carotid incision was made along the anterior border of the left sternocleidomastoid muscle. A hematoma was evacuated and the superior pole of the left lobe of the thyroid found to be fractured. The bleeding superior thyroid artery was ligated. The preoperative myelogram did not show any obstruction to the flow of contrast material within the spinal canal.

When a hemostat was passed through the entrance wound, it fell easily into the trachea, although there had not been any hissing sounds coming from the entrance wound before operation. Disruption of the first and second tracheal rings anteriorly and laterally on the left became apparent. These were totally fragmented. After debridement, a tracheostomy was established through the entrance wound directly into the trachea. The lateral wall of the trachea was reapproximated with a couple of sutures. The esophagus was unremarkable except for a small hematoma of the wall, but there was no perforation. The course of the bullet was followed through the prevertebral fascia. No cerebrospinal fluid emanated from that wound. The carotid artery and internal jugular vein were intact. The bullet had passed between the trachea and esophagus and the carotid artery. A Penrose drain was placed in the wound and brought out through the incision. The Penrose was removed on the fourth postoperative day. The wound

healed well. The tracheostomy has been occluded and he now is able to speak clearly.

## Anatomy Reviewed

Before going on to the approach to the patient with penetrating neck wounds, I would like to first review the anatomy of the neck. The neck is divided into an anterior and posterior triangle by the sternocleidomastoid, which courses obliquely from the sternoclavicular joint to the mastoid process. The posterior cervical triangle is bordered by the sternocleidomastoid, the trapezius and the clavicle. It is further subdivided into a subclavian triangle by the posterior belly of the omohyoid. The structures that are deep to this include the brachial plexus. The anterior triangle is bordered by the midline, the inferior border of the ramus of the mandible and the sternocleidomastoid. It is further subdivided into four smaller triangles by the anterior and posterior bellies of the digastric, the submental trangle and the submandibular triangle. The anterior belly of the omohyoid further subdivides the anterior triangle into a carotid triangle and muscular triangle.

Just deep to the skin and subcutaneous tissue of the neck is the platysma muscle in the superficial facia of the neck, innervated by the cervical branch of the facial nerve. Deep to that is the investing or first layer of the deep fascia of the neck. In the posterior triangle, are the exterior jugular vein and multiple sensory nerves that exit posterior to the sternocleidomastoid to provide sensory innervation to the skin over both the anterior and posterior triangles (supraclavicular nerves). The investing fascia of the neck forms a cylinder that is a closed space. It then gives off septi into the deeper structures of the neck to form the prevertebral and pretracheal fascia. Because of this fixed cylinder of fascia, neck trauma is potentially life threatening. Should there be an expanding hematoma from a perforated carotid artery, for instance, this fixed cylinder will not expand, so that a hematoma presses inwardly, resulting in respiratory obstruction and potential cardiac arrest.

Deep to the superficial structures and the posterior triangle are the muscles of the posterior triangle, primarily the anterior, middle and posterior scalenes. The brachial plexus exists between the anterior and middle scalene muscles. The subclavian triangle is covered by the deep fascia. Deep to the strap muscles is the thyroid gland which hugs the trachea anteriorly and laterally. It is closely associated with the structures in the carotid triangle. The ansa cervicalis gives motor innervation to the infrahyoid muscles.

## Treatment Considerations

A patient with a penetrating neck wound requires rapid evaluation and rapid identification so that treatment can be instituted as promptly as possible. Massive blood loss is an obvious problem and blood should be drawn for typing and cross matching. A large bore needle should be used for intravenous fluids. Should massive blood loss be present, fluid replacement should be undertaken with balance salt solutions or albumin preparations until blood becomes available.

The second most important priority is the airway. With vascular injuries one must remember that the airway may be compressed by an expanding hematoma, even though the trachea has not been injured. Endotracheal intubation or an early tracheostomy must be considered. Direct pressure may be applied to the bleeding site. If this does not stop the bleeding and if the injury is in the root of the neck, a left thoracotomy may be required to obtain proximal control.

When the patient's condition is stable, he should be examined for associated injuries. The most common are pneumothorax or hemothorax. The cupola of the lung lies just medial to the first rib. Although it is deep to the scalene muscles, the cupola may be sufficiently high in the posterior triangle to be injured by a penetrating neck wound. It is essential that all neck wounds that penetrate the platysma muscle are explored. Some surgeons advocate observation in a patient who has a penetrating neck wound without physical evidence of injury to the deep structures of the neck. This opinion is based on the high incidence of negative neck explorations in such patients. That conservative approach is safe only when large numbers of patients with neck wounds are treated by experienced personnel. Routine probing of wounds in the emergency room should not be done, other than to pass a hemostat into the wound to determine if the platysma has been pierced. If the wound goes deeper, it should be explored in the operating room.

The cervical incisions for neck injury exploration are those that overlie the great vessels, because these are the most life-threatening of in-

juries. An oblique incision along the anterior border of the sternocleidomastoid is useful for exposing of the contents of the carotid triangle. The transverse incision overlying the clavicle medially along with resection of the medial third of the clavicle effectively exposes the subclavian vessels. Either of these incisions can then be extended into a midline sternotomy incision if proximal control of blood vessels is not possible.

Esophageal injuries are life-threatening and have a high incidence of mortality secondary to infection. An esophageal perforation will dissect along the prevertebral fascia and extend into the mediastinum causing mediastinitis, empyema and usually death. Esophageal injuries should always be explored and the basic treatment is drainage of the neck. A perforation usually can be closed with two layers, using absorbable sutures for the inner layer and nonabsorbable sutures for the outer layer; however, adequate drainage is most important. Should a larger segment of the esophagus be injured secondary to a high velocity missle injury, then a cervical esophagostomy and pharyngostomy must be done along with drainage of the neck.

### Most Fatal Injuries

**Dr. James Wolf:** The two most life-threatening situations of penetrating wounds of the neck are either injuries of the carotid artery or injuries to the trachea itself. Patients with penetrating carotid artery injuries fall into two categories. The first is the patient who has a carotid artery injury but no neurological defect. The second is the patient with injury and a neurological defect.

I think that the controversy falls into three areas. First, whether or not to explore the patient with penetrating trauma. I personally think it is brinksmanship not to. The morbidity of a negative exploration is nil and the patient can be discharged in a few days. In my opinion, the safest approach is to explore patients with injuries in the anterior triangle.

The second area of controversy is whether or not to do an arteriogram of the carotid artery prior to exploring the neck. Here a proper approach is less clear. If a patient has neurological symptoms and does not have a bruit in his neck, I believe that he probably should have an arteriogram. This will determine whether the patient had an embolus from damaged intima or a carotid thrombosis, or whether the patient has some other reason for the neurological defect. I think an arteriogram also ought to be performed to prove that the carotid artery is normal should one decide not to operate on the patient. But I think that if the patient has minimal neurological symptoms, and evidence of hematoma, or as did this patient, evidence of crepitation of the neck, one must explore the patient. Then the use of the carotid arteriogram is a needless waste of time and one should move to the operating room before some catastrophic problem occurs.

In this patient, following the mylogram and not suspecting a carotid injury because the patient's neurologic defect was clearly due to his canal destruction and not to any carotid or CNS involvement, we explored the carotid and found it normal.

The manner in which one handles carotid injuries has now been clarified. The choices are ligation or repair of the carotid artery. Most surgeons would agree that if a patient has a serious neurologic defect, such as coma or a deep hemiplegia, revascularizing a carotid artery, (particularly, if it is occluded or there is clot proximal) is likely to turn the cerebral injury from an anemic infarct to hemorrhagic infarct. A number of deaths have been reported because such arteries were revascularized. Patients with severe neurologic defects and divided carotid arteries ought to have their arteries ligated. But the arteries of all other patients, those with neurologic defect or patients with minimum defects, should be repaired if possible. A note of caution here—one should not do the neurologic exam when the patient is in shock. A number of patients with carotid injuries have shown deep hemiplegia while in shock, but as soon as their blood pressures were brought back to normal the defect was found to be very minor.

The chosen method for correcting the defect in the artery, be it penetration, perforation or transection, requires primary repair after proper debridement, using autologous vein or dacron patch if necessary to bridge the defect.

We learned a lesson from the Viet Nam war. Revascularization of a deep hemiplegia and a carotid artery that is transected and with no flow through it will, in at least 50% of the cases, produce death of the patient.

**Dr. John Sanders:** I think this patient was treated correctly. Extent of damage is the big question in tracheal injuries. In anterior wounds that involve part of one or two cartilages, as this one did, the use of a tracheostomy is perfectly reasonable. If the wound avulses more than about one-quarter of the circumference, resec-

tion of one or two rings as a primary procedure must be considered, rather than trying to rely upon the tracheostomy for healing.

Knowledge of trachea anatomy is crucial. Surgeons most often consider the trachea as it is seen through an incision for tracheotomy or thyroidectomy. We often forget that most of the blood supply to the trachea comes from the lateral portion while very little enters anteriorly or posteriorly. Therefore, any mobilization of the trachea to close the defect cannot be done laterally or devascularization will result. The blood supply is derived from the inferior thyroid artery, from the small branches of the subclavian and from some of the branches of the supreme intercostal and internal mammary vessels as they give their branches to the mediastinum.

One of the impressive things about the trachea is that four or five tracheal rings can be visualized with the patient's neck hyperextended. When the head is in the normal position or slightly flexed anteriorily, most of the trachea disappears within the chest.

The most common site of trachea injury is high and may include the larynx itself. These injuries usually can be repaired through a simple collar incision. If you flex the neck, one or two tracheal rings can be resected without mobilizing a great deal of trachea except by finger dissection, anteriorly or posteriorly. Many of the early disasters of tracheal reconstruction came from the detachment of the lateral blood supply to the trachea. If more room is needed, an extension of the collar incision down through the sternum will allow retraction of the innominate vein superiorly or inferiorly and access to the trachea almost all the way down to the corina. If more length is needed, four or five rings can be resected by freeing up the trachea anteriorly and posteriorly and by dividing the inferior pulmonary ligaments. Some people talk about dividing the suspensory ligaments of the larynx to allow the larynx itself to fall forward. When combined with flexion of the head, this method allows a fair amount of mobility of the trachea and permits an end-to-end anastomosis.

### Intubation Procedure

Once the trachea has been transected, intubation can be carried out with a sterile connector and an andeotracheal tube passed directly into the trachea itself or directly into one of the main stem brochi. Ventilation of even one lung is usually satisfactory to complete the procedure.

It is, of course, preferable to ventilate both lungs.

Interrupted nonabsorbable suture technique is usually used. These are, generally speaking, simple sutures which go around the cartilage superiorly and inferiorly. Sutures in the posterior membranous portion must be tied last, because there is no strength to this and it is primarily a matter of sealing the anastomosis once the supporting sutures have been tied down.

It has been recently suggested that it may be better to place mattress sutures high in the trachea and low in the trachea and to bring the trachea together, using an absorbable suture technique to anastomose the trachea itself. It is claimed that this allows less interference with blood supply, since the tension is borne not by the anastomosis, but by supporting structures. I have no experience with this, but it is worth bearing in mind as something to watch as experience accumulates.

A cervical collar or a plaster cast may be used to maintain the forward flexion of the head for a period of about a week to ten days while the anastomosis heals. The anastomosis can be supported either with an endotracheal tube and tracheostomy carried out above it or with a natural airway if the patient is capable of cooperating and coughing. Obviously, it would be advantageous not to pass a tracheostomy through the suture line itself if possible.

The case that was presented today is an exception to that in that no tracheal wall was resected and only a small portion of the lateral wound was brought together to close the wedge-shaped defect. The anterior portion of the tracheal defect was then used for the tracheostomy.

**Dr. James Hines:** I was involved in the controversy over whether or not to explore neck wounds during the Korean War. It was found that the collecting platoons and clearing companies were exploring neck wounds and had a high morbidity and mortality. It was decided that neck wounds would not be explored except under the best of conditions, which would be in a hospital where adequate help and facilities were available. This merits emphasis. Neck wounds should not be explored at the site of the injury or in the emergency room, but only in the operating room under optimum conditions, with appropriate support staff. ◄

# *EKG*

*(Continued from page 432)*

**Answers: 1. E. 2. D.**

The ECG shows sinus bradycardia at a rate of 48 beats per minute. The third beat is a premature atrial beat that distorts the T wave of the preceding beat only slightly. The PR interval of the fourth beat is prolonged, which suggests that the atrioventricular node is still refractory from the premature atrial beat. This is an example of concealed conduction. The seventh, eight, ninth, and tenth beats occur at a slightly shorter cycle length, 1180 to 1220 msec. and represent an ectopic atrial rhythm or a junctional rhythm. Note the change in the P wave contour seen best in lead III (line 3). No treatment is required for this other than careful ECG monitoring. He was cleared for surgery and a left nephroureterectomy was performed. A papillary transitional cell carcinoma grade II found in the left renal pelvis and was completely resected. ◄

LEASE NOW

PORSCHE 911
The ultimate sports machine. We have the largest inventory in the midwest.



AUDI 5000
The sensible luxury car. All types of leases available, long or short term.



NOW RESERVING LEASE DATES FOR PORSCHE 928's!

Doctors have special transportation needs and we have been filling them with incomparable automobiles for years. Leasing your next car makes good economic sense and we'd like to show you why.

O'HARE
INTERNATIONAL AUTOS
The Midwest's Largest Porsche, Audi and Mazda Dealer
CALL VINCE PISHA (312) 297-2880

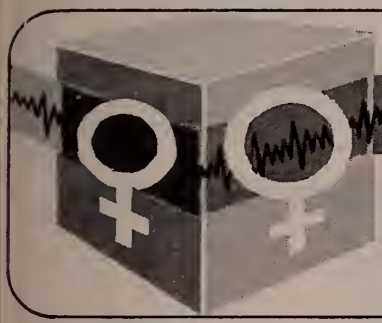
★

*Specialized Service*
IN
PROFESSIONAL LIABILITY INSURANCE
*is a high mark of distinction*

THE
MEDICAL PROTECTIVE COMPANY
FORT WAYNE, INDIANA

*Professional Protection Exclusively since 1899*

CHICAGO AREA OFFICE:
T. J. Pandak, J. C. Kunches, L. R. Gannon, and W. G. Prangle, Representatives
814 Commerce Drive, Suite 101B, Oak Brook, Illinois 60521 (312) 325-7314
SPRINGFIELD OFFICE: W. J. Nattermann, Representative
426½ South Fifth Street, Springfield 62701 (217) 544-2251



# *pulse...* of the ISMS auxiliary

Mrs. Eugene Vickery, Editor



## *Growth Patterns*

# Progress Update

Mrs. Earl V. Klaren, President, ISMSA

Our garden is planted, our hopes are high, and we look forward to a future harvest of successful auxiliary projects.

The myriad of seeds sewn during "project previews" at our 50th year celebration have taken root, and are rapidly developing in the nourishing environment of our members' enthusiasm.

State board members and committee chairmen have taken advantage of this early start with mailings to their respective county workers. Guidelines, goals, and pertinent facts are already in the hands of presidents and board members. All are hopefully preparing to provide a healthy yield of community service programs in home counties.

Members have been urged to participate in community summer round-ups and help school officials to distribute health-related information. They can also work to encourage completed immunizations of children entering their schools.

Community "language banks" were suggested to track down teen-agers and older persons lacking health clearances and immunizations when entering this country. Individuals without benefit of proper papers are weak links in U.S. disease prevention programs. Most are reluctant to come forward to receive care for themselves or their children. It is felt they would be more willing to participate if reassured by someone speaking their own tongue. This segment of the population must be reached if we are to stem the resurgence of diseases formerly thought to be eliminated or under control.

Our garden perennials, AMA-ERF, legislation, membership, and other health projects will continue their healthy growth without interruption.

A resolution was passed at the 1977 summer board meeting to promote and support a public relations press release entitled "fifty years of community service in Illinois." This would be funded through the sale of ads to friends of medicine.

The release might take the form of a supplement in the Chicago Sunday Tribune—Midwest

*(Continued on page 484)*

# report

Illinois Society
American Association of Medical Assistants

## 22nd Annual Meeting Scenes—



Mabel Ann Veech, Trustee AAMA of Kentucky, Vivian Kraft, CMA-AC President, Leslie Lee newly installed president.



Impressive representation of Chapter Presidents from all parts of Illinois.



Mrs. Jane Klaren, Presid ISMS Auxiliary is welcomed the Awards Luncheon.



Judith Miller, CMA-AC, president pro-tem, receives charter for newly established West-Cook Chapter.



Physician Advisors—Drs. Allison Burdick, Sr., John L. Wright and Thomas R. Harwood.



Dr. Samuel L. An man, Director Health—Skokie. note speaker at augural Banquet.



For outstanding services Leslie Schwartz, M.D. physician advisor receives "Honorary Membership" certificate presented by Magda Brown, Chairman Board of Trustees.



"Jessie"



Mrs. Synobia Payne, convention chairman



Mrs. Norma D anic, LPN, Tr AAMA



Attentive audience learns about Time Management led by Roger Fritz, Ph.D.




Chairman of Physician's Advisory Board John L. Wright, M.D. greets members at the President's Banquet. (left) Vivian Kraft, CMA-AC, (right) Mrs. June Hall, CMA-A.



Dr. Philip L. White of AMA.



Luella Mitchell, Program Co-ordinator with Mr. E. G. Metcalf program speaker listens to Philip L. White, Sc.D. Director of Food and Nutrition of AMA.



Skokie Mayor Albert J. Smith congratulates Vivian Kraft, CMA-AC, President.



Certificate of Appreciation is received by Allison Burdick, Sr. M.D.

The Annual Meeting was educational, enlightening, and fun. A large group of members and many guests participated. More will be reported in the future, but these pictures show some of the more important events. See you there next year.

**LOW-COST GROUP INSURANCE ANOTHER ISMS MEMBERSHIP PRIVILEGE**

**THE GROUP DISABILITY PLAN** ● Provides up to $1,732.00 monthly in the event of disability caused by Accident or Sickness. ● Special Guaranteed renewal feature. ● Protect your income and security.

**BUSINESS OVERHEAD EXPENSE PLAN** ● Pays your office overhead expense when disability strikes. ● Premiums are Tax Deductible. ● Pays in Addition to the Disability Plan Benefits.

**THE BASIC MAJOR MEDICAL EXPENSE PLAN** ● In or out of Hospital Benefits up to $25,000.00 per Disability. ● Up to $100.00 Daily Hospital Room and Board maximum. ● Subject to choice of deductible and 80% coinsurance.

**EXCESS MAJOR MEDICAL PLAN** ● Provides up to $250,000 for Medical Expenses. ● Supplements **any** Basic Major Medical Plan and has a $25,000 deductible. ● Low group rates. ● Truly **catastrophic coverage.**

FOR INFORMATION, ASSISTANCE & DETAILS CONTACT:

Administrators:
PARKER, ALESHIRE & COMPANY
ESTABLISHED 1901
Insurance

**9933 N. Lawler Avenue**
**Skokie, Illinois 60076**
**Phone: 312-679-1000**

# ISMS Guide to Continuing Medical Education

Compiled for Illinois physicians by the
ILLINOIS COUNCIL ON CONTINUING MEDICAL EDUCATION
55 E. Monroe St., Suite 3510 • Chicago, IL 60603 • (312) 236-6110

*Items for this Calendar must be received 90 days prior to the event. Those received earlier may appear in up to three monthly issues.*

*WARNING! Items for this Calendar come from many sources, often far in advance of the publication date. Sometimes, cancellations or changes in date, place or time occur too late to be corrected before publication. You are urged to contact the sponsoring organization to confirm information given below.*

## JULY

### *Family Medicine*

**SPECIALTY REVIEW FOR FAMILY PRACTICE**
**For:** Family Practitioners. 11-day lecture, beginning July 17, 8:30 a.m., Chicago, Illinois. **Speaker:** Harry Marchmont Robinson, M.D. **CME credit:** AAFP Elective, 98 hours; AMA category 1, 98 hours. **Fee:** $400. **Reg. limit:** 200. **Sponsor:** Cook County School of Medicine, 707 South Wood Street, Chicago, Illinois 60612. **Contact:** Robert J. Baker, M.D., Dean. **Telephone:** 312-733-2800.

### *General Medicine*

**ADULT RESPIRATORY DISTRESS SYNDROME**
**For:** M.D.'s. Lecture, July 11, 5:00 PM, Henrotin Hospital Board Room, Chicago. **Speaker:** Manzoor Shah, M.D., Director of Respiratory Services. **CME credit:** AMA Category 1, 1 hour. **Fee:** none. **Sponsor:** Henrotin Hospital, 111 West Oak Street, Chicago, IL 60610. **Contact:** William N. Werner, M.D., Associate Director of Med. Education. **Phone:** 312-440-7753.

### *General Practice, Orthopedic Surgery and Rehabilitation Medicine*

**MYOFASCIAL PAIN SYNDROMES—RECOGNITION AND TREATMENT**
**For:** Physicians & Allied Health Personnel. Lecture, July 17, 8:30 AM-12:45 PM, Motor Lodge, 600 N. Lake Shore Dr., Chicago. **Fee:** $25. **CME credit.** AMA Category 1, 4 hours. **Sponsor:** Chicago Medical School, 2020 W. Ogden, Chicago, IL 60612. **Co-Sponsor:** 22nd National Rehabilitation Conference. **Contact:** Eugene J. Rogers, M.D. **Telephone:** 312-942-2755.

### *Medicine*

**SPECIALTY REVIEW COURSE IN INTERNAL MEDICINE/CERTIFYING (PREP. FOR BOARD)**
**For:** Internists. 6½ day lecture, beginning July 30 & August 6, 1:00 p.m., Chicago, Illinois. **Speaker:** Sheldon S. Waldstein, M.D. **CME credit:** AMA Category 1, 64 hours. **Fee:** $275. **Reg. limit:** 600. **Sponsor:** Cook County Graduate School of Medicine, 707 South Wood Street, Chicago, Illinois 60612. **Contact:** Robert J. Baker, M.D., Dean. **Telephone:** 312-733-2800.

### *Pediatrics*

**SPECIALTY REVIEW IN PEDIATRICS**
**For:** Pediatricians. 5½ day lecture, July 10-15, 8:30 a.m., Chicago, Illinois. **Speaker:** Ira DuBrow, M.D. **CME credit:** 44 hours, AMA catgeory 1. **Fee:** $250. **Reg. limit:** 200. **Sponsor:** Cook County Graduate School of Medicine, 707 South Wood Street, Chicago, Illinois 60612. **Contact:** Robert J. Baker, M.D., Dean **Telephone:** 312-733-2800.

### *Physical Medicine & Rehabilitation*

**ELECTROMYOGRAPHY XX**
**For:** Physiatrists, Neurologists, Electromygraphers. 5-day course, July 10-14, Columbus, OH. **CME credit:** AMA Category 1, 30 hours. **Fee:** $200. **Reg. limit:** 60. **Sponsor:** Ohio State University, David Wiechers, M.D., 2172 West 8th Ave., Columbus, OH 43210. **Co-Sponsor:** American Academy of Physical Medicine & Rehabilitation. **Contact:** Victoria Severson, AAPM&R. **Telephone:** 312-236-9542.

### *Radiology*

**RADIATION SAFETY & DIAGNOSTIC RADIOLOGY**
**For:** Radiologists. 3-day lecture, July 24-26, 8:00 a.m., Chicago, Illinois. **Speaker:** Theodore Fields, M.S. **CME credit:** 24 hours, AMA category 1. **Fee:** $175. **Reg. limit:** 75. **Sponsor:** Cook County Graduate School of Medicine, 707 South Wood Street, Chicago, Illinois 60612. **Contact:** Robert J. Baker, M.D., Dean. **Telephone:** 312-733-2800.

### *Surgery*

**ADVANCED PERIPHERAL VASCULAR SURGERY**
**For:** Peripheral Vascular Surgeons 5-day lecture, July 17-21, 9:00 a.m., Chicago, Illinois. **Speaker:** Robert J. Baker, M.D. **CME credit:** AAFP elective, 40 hours; AMA category 1, 40 hours. **Fee:** $225. **Reg. limit:** 60. **Sponsor:** Cook County Graduate School of Medicine, 707 South Wood Street, Chicago, Illinois 60612. **Contact:** Robert J. Baker, M.D., Dean. **Telephone:** 312-733-2800.

### *Surgery*

**FIBEROPTIC COLONOSCOPY**
**For:** Surgeons, Internists & Family Practitioners. 3-day lecture, July 12-14, 9:00 a.m., Chicago, Illinois. **Speaker:** Herand Abcarian, M.D. **CME credit:** AAFP elective, 19 hours; AMA category 1, 19 hours. **Fee:** $300. **Reg. limit:** 15, **Sponsor:** Cook County Graduate School of Medicine, 707 South Wood Street, Chicago, Illinois 60612. **Contact:** Robert J. Baker, M.D., Dean. **Telephone:** 312-733-2800.

### *Surgery*

**FIBEROPTIC ESOPHAGOGASTRIC ENDOSCOPY**
**For:** Surgeons & Internists. 3-day lecture, July 12-14, 9:00 a.m., Chicago, Illinois. **Speaker:** C. Thomas Bombeck, M.D. **CME credit:** AAFP elective, 19½ hours; AMA category 1, 19½ hours. **Fee:** $300. **Reg. limit:** 15. **Sponsor:** Cook County Graduate School of Medicine, 707 South Wood Street, Chicago, Illinois 60612. **Contact:** Robert J. Baker, M.D., Dean. **Telephone:** 312-733-2800.

### *Surgery, Medicine, Cardiology*

**CORONARY CIRCULATION AND BY-PASS SURGERY**
**For:** All interested Physicians. Lecture, July 12, 7:45 PM, Chicago. **Speaker:** David Sabiston, Jr., Professor & Chairman, Dept. of Surgery, Duke University Medical Center. **CME credit:** AMA Category 1, 1.5 hours. **Fee:** none. **Sponsor:** Louis A. Weiss Memorial Hospital, 4646 No. Marine Dr., Chicago, IL 60640. **Contact:** Barry J. Millman. **Telephone:** 312-878-8700 x 304.

**The *American Society for Clinical Pharmacology and Therapeutics* offers a Continuing Medical Education Program directed toward the practicing physician. Speakers are available from the Society's excellent speaker's bureau. Contact: Elaine Galasso, 1718 Gallagher Rd., Norristown, PA 19401.**

## AUGUST

### *Emergency Medicine*

**SEVENTH ANNUAL TRAUMA CRITICAL CARE SYMPOSIUM**
**For:** All emergency medical personnel. Lecture/technique sessions, Chicago, IL. **Beginning dates:** 8/31, 9/1. **Fee:** $70. **Reg. limit:** 800. **Sponsor:** Illinois Department of Public Health Services, Division of Emergency Medical Services, 160 North LaSalle, Chicago, IL 60601. **Co-Sponsors:** American Trauma Society, Illinois Chapter; Emergency Department Nurses Association, Illinois Chapter. **Contact:** Penny Finn, Coordinator, 525 West Jefferson, Springfield IL 62761. **Phone:** 217-785-2080.

### *Family Medicine*

**PRIMARY CARE: A VIEW TOWARD THE 80'S**
**For:** Family Physicians, Internists, Pediatricians. 3 day conference (½ day each day), August 17-19 Interlaken Lodge/Villas, Lake Geneva, Wisconsin. **CME credit:** AMA, Category 1, 15 hours. **Fee:** $80. **Sponsor:** Dept. of Medical Education, Ravenswood Hospital Medical Center, 4550 No. Winchester, Chicago, IL 60640. **Contact:** Mara Harrington, Secretary. **Telephone:** 312-878-4300.

### *Internal Medicine*

**STATE & NATIONAL BOARD REVIEW, BASIC**
**For:** Internists. 6½ day lecture, August 6-12, Chicago, IL. **Speaker:** Sheldon S. Waldstein, M.D. **CME Credit:** AAFP Prescribed, 58 hours; AMA Category 1 58 hours. **Fee:** $275. **Reg. limit:** 150. **Sponsor:** Cook County Graduate School of Medicine, 707 South Wood Street, Chicago, IL 60612. **Contact:** Robert J. Baker M.D., Dean. **Phone:** 312-733-2800.

### *Internal Medicine*

**STATE & NATIONAL BOARD REVIEW, CLINICAL**
**For:** Internists, family practitioners. Lecture, August 14-19, Chicago, IL. **Speaker:** Sheldon S. Waldstein M.D., **CME credit:** AAFP Prescribed, 53 hours; AMA Category 1, 53 hours. **Fee:** $250. **Reg. limit:** 150 **Sponsor:** Cook County Graduate School of Medicine 707 South Wood Street, Chicago, IL 60612. **Contact** Robert J. Baker, M.D., Dean. **Phone:** 312-733-2800

### *Orthopaedic*

**SPECIALTY REVIEW IN ORTHOPAEDICS**
**For:** Orthopaedists. 7 day lecture, August 13-19. Chicago, IL. **Speaker:** Peter C. Altner, M.D. **CME credit** AAFP Elective, 64 hours; AMA Category 1, 64 hours **Fee:** $275. **Reg. limit:** 350. **Sponsor:** Cook County Graduate School of Medicine, 707 South Wood Street Chicago, IL 60612. **Contact:** Robert J. Baker, M.D Dean. **Phone:** 312-733-2800.

### *Physical Medicine & Rehabilitation*

**ELECTROMYOGRAPHY & CLINICAL NEUROPHYSIOLOGY**
**For:** Physiatrists & interested Physicians. 3-day course August 16-18, Chicago, IL. **CME credit:** AMA Category 1, 21 hours. **Reg. limit:** 40. **Fee:** $175, physician $90, residents. **Sponsor:** Rehabilitation Institute Chicago, 345 E. Superior St., Chicago, IL 60611 **Co-Sponsor:** American Academy of Physical Medicine & Rehabilitation. **Contact:** Victoria Severson, AAPM& **Telephone:** 312-236-9512.

## EPTEMBER

### Cancer

**TH ANNUAL CHICAGO SYMPOSIUM "CANCER MUNOLOGY: EXPERIMENTAL AND CLINICAL"**
Oncologists, Surgeons, Internists, Hematologists. ay symposium, September 13-15, Pick-Congress el, Chicago. Speaker: George Mathe, M.D., Direc- Institute of Cancerologie Et D'Immunogenetique, is. CME credit: AMA Category 1, 16 hours. Reg. dline: 9/1. Reg. limit: 200. Fee: $70. Sponsor: Biomedical Research of the University of Illinois So. Sangamon St., Chicago, IL. Co-Sponsors: ois Cancer Council, American Cancer Society. ntact: Nancy Piekarski. Telephone: 312-996-4688.

### Clinical Laboratory Correlation

Physicians. Lecture/Discussion, Sept. '78-June (Thursdays, bi-weekly), Mattoon, IL. CME credit: A Category 1. Fee: none. Reg. limit: none. Spon- Sarah Bush Lincoln Health Center, R.R. 16, Box , Mattoon, IL 61938. Contact: Byron Ruskin, M.D. phone: 217-258-2514.

### Hypnosis

**RKSHOP ON CLINICAL HYPNOSIS**
Physicians, Dentists, Psychologists. 4-day work- p, September 14-17, Chicago, IL. CME credit: A Category 1, 25 hours; Academy of General Den- y, 25 hours. Fee: $225. Reg. limit: none. Spon- American Society of Clinical Hypnosis—Education Research Foundation, 2400 E. Devon Ave., Suite 2 , Des Plaines, IL 60018. Contact: William F. Hoff- , Jr. Telephone: 312-297-3317,

### Infectious Disease/Urology

**T MEDICAL/SURGICAL SEMINAR FOR E COUNTY**
M.D.'s, D.D.S.'s, R.N.'s, Rh.P.'s Seminar, ember 20, 8:00 AM-1:00 PM, Waukegan, IL credit: AAFP Elective, 5 hours; AMA Category hours. Reg. deadline: 9/20. Reg. limit: none. $2.50, staff; $5.00, non-staff. Sponsor: St. ese Hospital, 2615 Washington, Waukegan, IL 35. Contact: R. M. Adelman. Telephone: 312-688- .

### Internal Medicine

**DIAC EMERGENCY**
all Physicians. Symposium, September 26, alia, IL. CME credit: AAFP Elective, 3 hours; Category 1, 3 hours. Reg. limit: none. Sponsor: hern Illinois University School of Medicine, P.O. 3926, Springfield, IL 62708. Contact: Lorrain henson. Telephone: 217-782-7711.

### Internal Medicine

**UNOLOGY AND IMMUNODEFICIENCIES ORDERS**
all Physicians. Symposium, September 21, cy, IL. CME credit: AAFP Elective, 4 hours; Category 1, 4 hours. Reg. limit: none. Sponsor: hern Illinois University School of Medicine, P.O. 3926, Springfield, IL 62708. Contact: Lorraine henson. Telephone: 217-782-7711.

### Internal Medicine

**AGEMENT OF OFFICE UROLOGICAL PROBLEMS**
all Physicians. Symposium, September 14, Mt. el, IL. CME credit: AAFP Elective, 4 hours; AMA gory 1, 4 hours. Reg. limit: none. Sponsor: South- Illinois University School of Medicine, P.O. Box , Springfield, IL 62708. Contact: Lorraine Step- on. Telephone: 217-782-7711.

### Internal Medicine

**TE ON CLINICAL IMMUNOLOGY SYMPOSIUM CHEDULED)**
ll Physicians. Symposium, September 7, Carbon- IL. CME credit: AAFP Elective, 4 hours; AMA ory 1, 4 hours. Reg. limit: none. Sponsor: ern Illinois University School of Medicine, P.O. 3926, Springfield, IL 62708. Contact: Lorraine enson. Telephone: 217-782-7711.

### Medicine, Surgery

**AVENOUS HYPERALIMENTATION & DISEASE**
all interested Physicians. Lecture, September 19, p.m., Chicago, IL. Speaker: Stanley J. Dudrick, Professor & Chairman, Dept. of Surgery, Uni- y of Texas Medical School, Houston. CME credit: Category 1, 2 hours. Reg. deadline: none. Fee: Sponsor: Louis A. Weiss Memorial Hospital, No. Marine Dr., Chicago, IL 60640. Co-Sponsor: A. Strauss Memorial Lecture. Contact: Barry J. an. Telephone: 312-878-8700 x 304.

### Ophthalmology

**SEMI-ANNUAL COURSE FOR ANTERIOR AND POSTERIOR SEGMENT VITRECTOMY**
For: Ophthalmologists. 2-day course, September 22-23, University of Illinois Eye & Ear Infirmary, Chicago, IL. CME credit: AMA Category 1, 16 hours. Reg. limit: 15. Fee: $250. Sponsor: Dept. of Ophthalmology, University of Illinois, 1855 W. Taylor, Chicago, IL 60612. Contact: Carmen Carrasco. Telephone: 312-996-8024.

### Orthopedics

**BACK INJURIES & BACK PAIN RELATED TO SPORTS INJURIES**
For: all Physicians. Symposium, September 13, Wood River, IL. Reg. limit: none. CME credit: AMA Category 1, 4 hours; AAFP Elective, 4 hours. Sponsor: Southern Illinois University School of Medicine, P.O. Box 3926, Springfield, IL 62708. Contact: Lorraine Stephenson. Telephone: 217-782-7711.

### Pediatrics

**PEDIATRIC REVIEW**
For: all Physicians. Symposium, September 28, Sparta, IL. CME credit: AAFP Elective, 4 hours; AMA Category 1, 4 hours. Reg. limit: none. Sponsor: Southern Illinois University School of Medicine, P.O. Box 3926. Springfield, IL 62708. Contact: Lorraine Stephenson. Telephone: 217-782-7711.

### Pediatrics

**SECOND ANNUAL SYMPOSIUM ON MEDICAL GENETICS**
For: all Physicians. 1-day symposium, September 15, Springfield, IL. CME credit: AAFP Elective, 7 hours; AMA Category 1, 7 hours. Reg. limit: none. Sponsor: Southern Illinois University School of Medicine, P.O. Box 3926, Springfield, IL 62708. Contact: Lorraine Stephenson. Telephone: 217-782-7711.

### Physical Medicine & Rehabilitation

**THIRD ANNUAL COURSE ON MANAGEMENT OF THE SPINAL CORD INJURED PATIENT**
For: Physicians & professionals in acute spinal cord management. 5-day course, September 11-15, Chicago, IL. CME credit: AMA Category 1, 32 hours. Fee: $200, physicians; $125, residents. Reg. limit: 115. Sponsor: Rehabilitation Institute of Chicago, 345 E. Superior St., Chicago, IL 60611. Co-Sponsor: American Academy of Physical Medicine and Rehabilitation. Contact: Victoria Severson, AAPM&R, 30 No. Michigan, Chicago, IL 60611. Telephone: 312-236-9512.


***Would an Outside View Help your Hospital CME?***

**The Illinois Hospital CME Consultation service can improve your in-hospital CME by helping you to build an up-to-date conception designed to enhance *individual physicians' full clinical potential*—and discard stereotyped group efforts to "keep up." The two-part process begins with *self*-analysis using a unique 16-page booklet—FREE to Illinois hospitals. The second part involves a personal visit and report by an expert on effective in-hospital CME; for the Consultant's visit, a modest charge is necessary to cover his honorarium, travel, and related costs.**

**For full information, ask for the "Consultation booklet"; write or call . . .**

**Illinois Council/CME**
**55 E. Monroe St., Suite 3510**
**Chicago, IL 60603**
**(312) 236-6110**


### Physical Medicine & Rehabilitation

**PERSPECTIVES IN CHRONIC MEDICINE**
For: Physiatrists & Family Physicians. 4-day course, September 20-23, Chicago, IL. Reg. deadline: 8/31. CME credit: AMA Category 1, 20 hours. Reg. limit: 80. Fee: $200, physicians; $150, residents, nurses, allied health personnel. Sponsor: Rehabilitation Institute of Chicago, 345 E. Superior St., Chicago, IL 60611. Co-Sponsors: American Academy of Physical Medicine & Rehabilitation, American College of Physicians, Northwestern University Medical School. Contact: Victoria Severson, AAPM&R, 30 No. Michigan, Chicago, IL 60611. Telephone: 312-236-9512.

### Surgery

**VISITING PROFESSOR PROGRAM**
For: Physicians, students, residents. Lecture, Sept. '78-May '79 (2nd Wednesday/mo.), 9:00 AM-4:00PM, VA Hospital, The Chicago Medical School, North Chicago, IL. CME credit: AMA Category 1, 5 hours (ea. session). Reg. limit: none. Reg. deadline: none. Fee: none. Sponsor: Dept. of Surgery, UHS/CMS, VA Hospital, North Chicago, IL 60064. Contact: Karen Jonasson. Telephone: 312-473-9200 x 202.

### Surgery

**PRE-OPERATIVE CARE OF THE SURGICAL PATIENT**
For: all Physicians. Symposium, September 21, East St. Louis, IL. CME credit: AAFP Elective, 4 hours; AMA Category 1, 4 hours. Reg. limit: none. Sponsor: Southern Illinois University School of Medicine, P.O. Box 3926, Springfield, IL 62708. Contact: Lorraine Stephenson. Telephone: 217-782-7711.

### Thoracic Diseases and Internal Medicine

**SCREENING PROGRAMS IN EARLY DIAGNOSIS OF LUNG CANCER**
For: Physicians, residents. Lecture, September 6, Auditorium, Martha Washington Hospital, 4055 N. Western Ave., Chicago, IL 60618. Speaker: David R. Sanderson, M.D., Mayo Medical School, Rochester, MN. CME credit: AAFP Elective, 1 hour; AMA Category 1, 1 hour. Reg. limit: none. Fee: none. Sponsor: Martha Washington Hospital Medical Staff. Contact: Fernando Villa, M.D. Telephone: 312-583-9000 x 331.

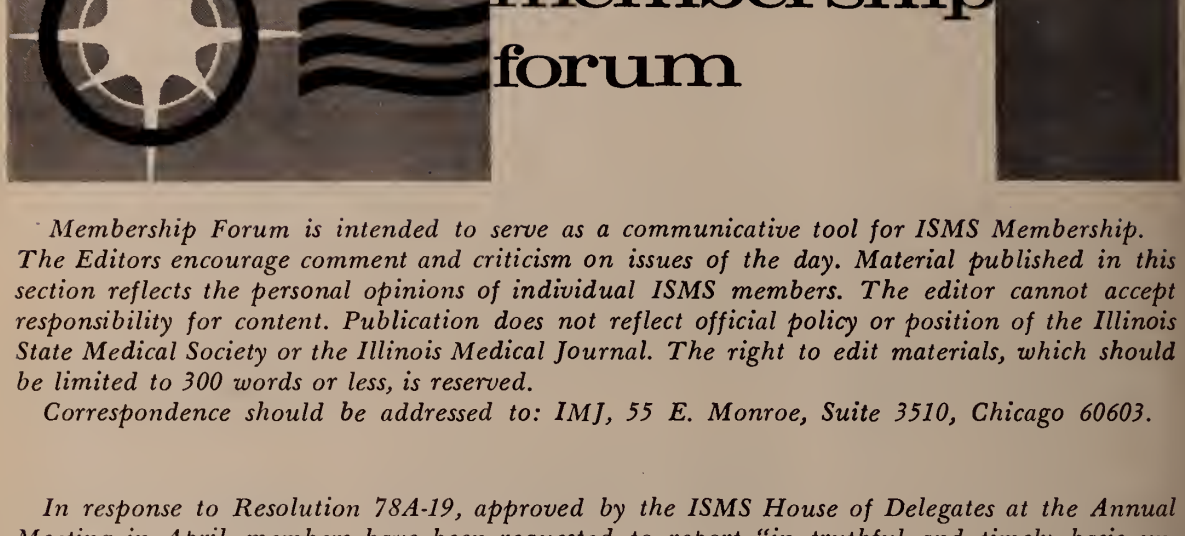

***Your Personal Learning Plan***

**Are you satisfied that your CME is producing full benefits for the time (and money) invested? If you've any doubts, try *Your Personal Learning Plan*, a 32-page pamphlet intended to help the individual physician plan CME in a systematic fashion.**

**While written chiefly for primary-care practitioners—family physicians, internists, pediatricians—the pamphlet can also be useful to those specialists who ordinarily deal with a smaller range of medical problems.**

**A unique feature of this handbook is a special set of worksheets—similar in format to the patient medical record—to help you think through and record YOUR personal learning plan.**

**Any Illinois physician (MD or DO) may have a copy FREE upon request; simply write "Personal Learning Plan" on your prescription form, and mail to ICCME *(address above)*. To all others, the cost is $3.00/copy postpaid ($2.70 each in quantities of 100 or more).**




*Membership Forum is intended to serve as a communicative tool for ISMS Membership. The Editors encourage comment and criticism on issues of the day. Material published in this section reflects the personal opinions of individual ISMS members. The editor cannot accept responsibility for content. Publication does not reflect official policy or position of the Illinois State Medical Society or the Illinois Medical Journal. The right to edit materials, which should be limited to 300 words or less, is reserved.*

*Correspondence should be addressed to: IMJ, 55 E. Monroe, Suite 3510, Chicago 60603.*

*In response to Resolution 78A-19, approved by the ISMS House of Delegates at the Annual Meeting in April, members have been requested to report "in truthful and timely basis unfavorable experience with third-party payors so that these experiences can be published in the IMJ Membership Forum, over the signature of the individual physician." ISMS members are encouraged to participate in this communicative effort.*

## Column Comment

Dear Sir,

My enthusiastic compliments on the first of perceptive articles on Professional Liability by Mr. Folonie (153, No. 2:104). As you may know I have entertained an intense interest in this problem, having been the subject of several suits, only one of which reached the jury with my exoneration. A few years ago, I instigated a national organization to mobilize *everyone* in the health industry to attack this problem through legislation by means of the million or so votes of physicians, nurses, hospitals, pharmaceutical industry, etc. Unfortunately the A.M.A. decided to "go it alone" and predictably not much has come of it.

Looking forward eagerly to more of Mr. Folonie's articles.

Sincerely,
George E. Shambaugh, Jr., M.D.
Hinsdale

## *The Future of Gastrointestinal Endoscopy*

When a decade or so ago the technology and clinical application of fiberoptic instruments were accepted in this country, it appeared that gastrointestinal surgery and medicine would rush into a new era. The fiberoptic technology offered new diagnosis to and beyond the ligament of Treiz. The endoscopic examination and surgery on the ampulla of Vater was a dramatic new step in medicine. In diagnosis of colonic disease, it exceeded the accuracy of X-ray. Endoscopic removal of polyps by averting laparatomy became a major triumph of gastrointestinal endoscopy. But in spite of these startling innovations, a revolution did not materialize. The present progress can be called a creeping evolution at best.

Endoscopy is, to a great extent, limited to major centers where receptively trained gastroenterologists are available. Information about the new technic spreads slowly. Gastroenterology will probably never get to small communities. The older generation of internists and surgeons are happy with their present practice. They abhor the technical difficulties of the discipline and not everyone has a manual aptitude to be an endoscopist. The postgraduate education of the older generation of physicians starts very slowly with short courses. At a recent postgraduate course an unhappy physician moaned: "I took a two week course and spent two weeks at the end of a teaching attachment. I did not do a single case." The education of the physicians at these short postgraduate courses is limited to did

ures and short hurried practices teaching models.

Yet this new method is not only the big teaching hospital. It has its ce and is needed in small com- nities. It even begins to find its way office practice. The investment is lest compared to the expensive dware of the scanners. It can diag- e in ways no X-ray can. It can op- e in ways no conventional sur- l procedures can.

The general surgeons are natural didates for this new diagnostic and rating tool. A good part of their k is gastrointestinal surgery. They and see the color, tecturem lumps ulcerations of the serosal and osal surfaces. Surgical pathology heir skill. One would expect that thoracic surgeon does his own nchoscopy or esophagoscopy. We ume that the GU surgeon does his cystoscopy or that the surgeon he lower GI tract does his own cto-sigmoidoscopy. It is reasonable ssume that the surgeon who oper- on the stomach, duodenum and n will perform his own diagnostic operative endoscopy. Training in rointestinal endoscopy should be of the education of all general eons. As the boundaries of medi- and surgical gastrointerology are ly well defined, there is a definite d for medical and surgical gastro- stinal endoscopists. It is time that integrate this new technology into training of all young surgeons. Its re appears to be bright.

James Scott, M.D., S.C.
Streator

## n Patient Privacy

r Sir:

his letter will concern the matter discussed on Tuesday, April 11. ou already know my feelings con- ing privacy of patients and I shall elaborate on that. However, this icular matter concerns a member ny family.

My mother is tentatively scheduled to enter the hospital for eye surgery. Although she is in her 80's, she will be admitted under a private insurance policy, and not under Medicare. I will be responsible for any expenses not paid by the insurance company. It is anticipated that her hospitalization will require only a few days.

I shall place on the medical chart my usual request: "This is a private patient. I therefore request that, unless she gives consent in writing, her medical records be examined only by those directly involved in her medical care. Any violation of this is a violation of patient privacy."

In addition I shall place a copy of this letter in the chart.

I think you know me well enough to know that the following statement is in no way intended as a threat. However, if my mother's medical records are scrutinized by other than those furnishing her medical care, it will necessitate legal action against those who do so.

I believe my request is a reasonable one. I believe my mother is entitled to privacy and I ask only what you would undoubtedly ask if it involved a member of your family.

Sincerely yours,
Max Klinghoffer, M.D.

## Ladies and Gentlemen

*"Do not say things. What you are stands over you the while and thunders so that I cannot hear what you say to the contrary."*

Ralph Waldo Emerson, 1803-1882

A lady or gentleman physician can successfully cope with a slob patient. The reverse is not true. A slob of a doctor cannot possibly establish rapport with gentle patients. I then hear the argument, "Don't judge me by my outer sloppy trappings, judge me by what's in here." But in answer, "What you are speaks so loudly that I cannot hear what you are saying."

An affable personality and persuasiveness are the most important characteristics for success in clinical medicine, it seems to me. These are qualities that can only be accurately assessed by a competent interviewer, an experienced interviewer who has interviewed many successful doctors and students. Part and parcel of an agreeable personality are traits we attribute to true ladies and gentlemen. "But a good research man doesn't need those characteristics," you might say. I'd counter, "To wheedle a grant these characteristics are even more important." In the choice of medical students, a successful researcher should be part of the interviewing team. A senior medical student should also be part of the team, for a student would be hypercritical, I'm certain because he or she'd be choosing his or her future associates. I understand this is the practice at Rush-Presbyterian-St. Luke's Hospital. Medical students should be in the best of health. Perhaps senior students should do physical exams on all applicants. This would give the seniors practice in routine physicals and also give them a chance to more than intimately assess applicants. In the choice of medical students, of course, academics are important, but I feel that personal assessment by interview is even more important.

I doubt if selection by personal interview could be abused if it is kept open. There might be bias in favor of children of physicians, but only because those children would be wiser in the ways of healing and be more aware of the qualities they'd emphasize in such an interview. To be fair there would have to be a minimum of three interviews in order to eliminate ties. Granted it would add hours of work for those on the selection committee. I for one would gladly give up an hour or so each week to help raise the standards of the next generation of physicians, to help find ladies and gentlemen with confident, positive and persuasive natures. No more slobs.

To paraphrase Emerson, "What you are speaks so loudly I cannot hear what you are saying."

Hugh A. Johnson, M.D.
Rockford

# Physician Recruitment Program

*In an effort to reduce the number of towns in Illinois needing physicians, the Physician Recruitment Program and the Doctor's Job Fair, are publishing synopses in the Journal.*

*Physicians who are seeking a place to practice or who know of any out-of-state physicians seeking an Illinois residence are asked to notify the Program.*

*Any areas wishing to be listed should contact: Mrs. E. Duffy, Physician Recruitment Program, ISMS, 55 E. Monroe, Suite 3510, Chicago, 60603.*

**BRAIDWOOD:** Physician for family practice, 20 miles south of Joliet—60 miles south of Chicago. No other doctor in town of 5,000. Next door to pharmacy. Clinic provided, substantial guaranteed income for 17 hours per week. One year contract. Contact: Ron Radley, Box 795, Braidwood 60408. (815) 458-2224 or (815) 634-4900. (6)

**CANTON:** Coleman Clinic, Ltd. Population 15,000; drawing area 60,000. Twelve physicians; multi-specialty clinic. Planning expansion program. Progressive city and clinic offering outstanding opportunity to primary care physician. Guaranteed salary and excellent benefits. Contact: H. E. Crouch, 175 S. Main St., Canton, 61520. (309) 647-0201. (6)

**CASEY:** Family physician. Practice quality rural medicine having advantage of group, but independence of solo practice. New complete facilities. Financial assistance available. This is the area to work, live, and enjoy families. Superb congenial doctors & colleagues to share your work. Before you decide, come see our operation. Contact: B. F. Vondracek, Casey Medical Center, Casey, 62420. (217) 932-4061. (6)

**CHADWICK:** Rural community in picturesque Northwestern Illinois, 125 miles west of Chicago. Need for a family physician in a solo practice or possible clinical association. Office space available. Contact: Harold Frank, 411 First St., Chadwick, 61014, (815) 684-5154 or 684-5147, Allen Smith, Rural Route, Chadwick, 61014, (815) 684-5200 or 684-5152. (6)

**CHICAGO:** Opportunities Available for Family Practitioners in a single specialty clinic setting. Association as a satellite facility with a 265 bed community hospital. Opportunity to build own practice with financial assistance available. Contact: Teryl R. Filebark, 1044 N. Francisco Ave., Chicago 60622. (312) 278-8800. (9)

**CHICAGO** (desirable suburb): Older general practitioner has excellent office facilities to share with younger G.P. Objective: need help with practice. Younger man may have guarantee to take over practice in near future. Hospital staff appointment available. All replies confidential. Box MK, Physician Recruitment Program, ISMS. (9)

**DOUGLAS COUNTY:** Population 20,000. Family practitioners needed in Villa Grove and Arcola. Twenty-five miles from Champaign and University of Illinois. 58 bed general acute hospital in Tuscola. Contact: J. Lindsey, Qualicare Inc., P.O. Box 24189, New Orleans, LA 70184, (504) 837-6456. (6)

**ELGIN:** Psychiatrist, ¾ time position with CMHC. Provide leadership and direction of medical and psychiatric aspects of clinical program, consult with staff, provide direct service to a wide variety of patients. Experience: past residency, preferably Board certified. Resume and salary requirements would be helpful to: Jack Crook, Director of Programs, Fox Valley Mental Health Center, 384 Division, Elgin, 60120, (312) 695-1115. (10)

**FAIRBURY:** Population 3,500. Rural area serving a population of more than 16,000. Excellent practice opportunity for family practitioner or internist interested in family practice. Enjoy life and your practice in an area which offers excellent facilities and a personal, friendly atmosphere; join the staff of 112-bed JCAH accredited community hospital. Write: Frank Brady, Administrator, Fairbury Hospital, Fairbury, 61739, or call collect (815) 692-2346. (10)

**FAIRFIELD:** Population 6,000. Rural area with a service population of 25,000. Seventy miles from Evansville, Indiana. Opening in medical clinic for obstetrician-gynecologist, family practitioner, or internist interested in doing family practice. Financial assistance available. Contact: Dr. Arthur Marks or Dr. Sigmund Konarski, 101 E. Center Street, Fairfield, 62837. Telephone: (618) 842-2187. (6)

**FORT MADISON, IOWA:** Openings for 2-4 FP/GP, Ped., in growing industrial city of 16,000 serving 70,000 on Mississippi River. Solo, partnership, clinic available. Substantial salary, other incentive. U. of Ia. near, excellent living area, 125 bed accredited hospital. Contact Donald A. Buckert, Fort Madison Community Hospital, Fort Madison, Ia. 52627. (319) 372-6530. (7)

**FREEPORT:** Internist-general internist or internist with sub-specialty, board certified or eligible to join multi-specialty group in community of 35,000 in Northern Illinois. Excellent salary first year then partnership. Excellent retirement and fringe benefits. Send curriculum vita and references to K. H. Shons, Business Manager, Freeport Medical Clinic, Ltd., 3103 West Stephenson Road, Freeport, 61032. (815) 235-6131 (7)

**GALESBURG:** Excellent opportunities in ENT, Family Practice, Internal Medicine, Ob-Gyn. West-central Illinois community of 40,000, manufacturing & agricultural center. Home of Knox College. Outstanding educational, recreational, and cultural environment. Financial incentives and new medical office building available. Contact: Marshal G. Maggard, President, Galesburg Cottage Hospital, Galesburg, 61401. (309) 343-8131. (6)

**HERRIN:** Population 10,000. Trade area 40,000. Located in beautiful vacationland of Southern Illinois, near major university and medical school. Family Practice and OB-Gyn needed. Solo or clinic available. Excellent financial program provided. Modern well equipped hospital. Call collect or write, Larry Feil, Herrin Hospital, Herrin, 62948—Tel. (618) 942-4710. (7)

**ILLINOIS:** The Illinois Department of Mental Health and Developmental Disabilities has opportunities in all areas of the state for psychiatrists and primary care physicians. M.D.'s and D.O.'s with Illinois licenses will be considered. Competitive salaries commensurate with training and experience; attractive fringe benefits. Contact: John T. Nelson, M.D., Coordinator of Medical Affairs, 750 South State Street, Elgin, 60120. (312) 742-1040, x321. (6)

**JACKSONVILLE:** Opportunities for family practice, internal medicine, ENT, orthopedic surgery, emergency room. Progressive 250 bed hospital, 40 member medical staff. Prosperous community with service area of 60,000, two colleges, excellent schools, 30 miles from medical school. Financial assistance, office facilities available. Contact: Bernie Gregory, Passavant Hospital, Jacksonville 62650. (217) 245-9541. (6)

**LIBERTYVILLE:** Family practice physician, general practitioner, or internist to join outpatient clinic in rapidly growing area near lakes, shopping centers, recreation areas, and easy access to Chicago theaters, museums and cultural events. Clinic consists of full auxiliary facilities, special procedure rooms and future outpatient surgical center. For information contact: Family Medical Center, Rt. 1, Box 351, Libertyville 60048, (312) 362-9097. (6)

**MENDOTA:** General practice, second physician for Wholistic Health Center of Mendota, Illinois. Innovative program with additional staff for counseling and patient education. Excellent local hospital. Future openings available in five other Wholistic Health Centers in the planning stage. Call or write: Lucy Young, M.D., 607 Tenth Ave., Mendota, 61342. (815) 539-3888 (7)

**MINIER:** General or family practitioner for rich agricultural area near Bloomington. Large practice waiting due to death of doctor. Office with X-ray and other equipment, very reasonable. Unusual opportunity. Contact: Harvey Graff, Minier 61759. (309) 392-2345 or 392-2120. (10)

**OTTAWA:** Opening in fields of Internal Medicine and Family Practice with multi-specialty group of nine physicians. Community, 20,000 plus. 154 bed hospital under five years old. Latest equipment One and one-half hours from Chicago and Peoria. Near State Parks. Excellent school system. Close to Jr. College and State Universities. Salary negotiable. CONTACT: Mrs. Van Buren, Ottawa Medical Center, 313 W. Madison, Ottawa 61350. (815) 433-1010. (10)

**PEORIA:** Emergency physician—Unique opportunity to start on the ground floor with fee-for-service group in 550-bed medical center seeing 27,000 ER visits. Need career-minded physician for three 16-hour shifts per week with four weeks paid vacation. Compensation 57K with excellent corporate benefits plus incentive compensation. Flexible scheduling to allow individual pursuits in university town of 250,000 in Central Illinois. Contact: Hospital Emergency Physicians S.C., 221 Northeast Glen Oak, Peoria, 61636; phone 309-672-4974. (8)

**PRINCETON:** Family physician & internist—population 10,000, lovely community with excellent school and recreational facilities. Excellent hospital facility built in early 1970's. New office building attached to hospital will be completed in Spring of 1978. Specialties of internal medicine, OB, orthopedics, pediatrics, surgery, and urology available to complement the family physician. Contact: Harold L. Autrey, 530 Park Avenue East, Princeton 61356. (815) 875-2811. (6)

**SPRINGFIELD:** Family practitioners — Springfield Community Hospital is looking for you to begin private practice in our new multi-specialty Community Medical Plaza. We offer an attractive package to help you get started. If interested, contact: W. H. Fields, Springfield Community Hospital, 5230 S. 6th St., Springfield, 62703. (217) 529-7151. (6)

**UNION COUNTY:** Population 17,000. Clinic and office facilities available for family practitioner and physician of internal medicine. Special Care Unit under construction in County Hospital. Nearby cities of Carbondale and Cape Girardeau 25 miles away. Recreational facilities plentiful. Contact: E. A. Helfrich, 517 N. Main, Anna, 62906 AC 618-833-5155. (7)

**WAUKEGAN:** Population 67,000, northern Chicago Suburb. Newly remodeled medical center near hospital. Looking for Internist, Family Physician. Contact Washington Center, 1515 Washington St., Waukegan 60085, Y. Lee, M.D. 312-336-2221 or 729-5407. (9)

# CLASSIFIED ADVERTISING

## POSITIONS & PRACTICE OPPORTUNITIES

**FULL TIME PHYSICIAN** for Industrial Clinic in Skokie. Surgical experience needed. Salary negotiable. Must have Illinois license. Call (312) 674-4800, Mrs. McCubbin.

**OPPORTUNITIES FOR PHYSICIANS IN INDIANA**—There are several excellent openings among the Indiana State Hospitals at various locations throughout the state for psychiatrists and physicians of other specialties, at most experience levels. A newly-revised salary schedule offers a very competitive income plus a generous package of fringe benefits. An adjunct practice is possible beyond the regular working hours and on-call responsibilities. Please reply with a copy of the c.v. to: Farabee & Associates, Inc., P.O. Box 472, Murray, KY 42071 or call (collect) (502) 753-9772. Farabee is retained by the Indiana Department of Mental Health.

**ACADEMIC DIRECTOR, INTERNAL MEDICINE:** University of Illinois affiliated community hospital seeks individual to be responsible for undergraduate, graduate and continuing medical education, and administration of residency and outpatient center. Physician we seek must be American Board of Internal Medicine certified. In return we offer a challenging and rewarding experience plus a competitive salary and benefit program. Send resume in complete confidence to: Box 917, c/o IMJ, 55 E. Monroe, Suite 3510, Chicago 60603.

**GENERAL PRACTITIONER** for office-based practice with multi-specialty group in western suburbs of Chicago. Attractive minimum guarantee salary plus incentive. Complete fringe benefit package. Write for details: Dave S. Bauer III, Administrator, Glen Ellyn Clinic, S.C., 454 Pennsylvania Ave., Glen Ellyn, IL 60137.

**OTOLARYNGOLOGIST** to join large multi-specialty group as second ENT doctor in western suburbs of Chicago. Very busy practice. Guaranteed base salary plus incentive; Early partnership. Complete fringe benefit package. Box 918, c/o IMJ, 55 E. Monroe, Suite 3510, Chicago, 60603.

**WANTED: INDUSTRIAL PHYSICIAN:** Unusual opportunity for Illinois licensed physician. Full time industrial work with minor traumatic surgery and physical examinations. Regular hours. Advancement for right person. Starting salary negotiable. Write to Box 920, c/o IMJ, 55 E. Monroe, Suite 3510, Chicago, 60603.

**ANESTHESIOLOGIST:** population 11,000—service area 30,000. Home of Monmouth College. Sixteen miles from the Mississippi. Close to large metropolitan area. Modern, well-equipped hospital. Contact: Roger E. Gurholt, Administrator, Community Memorial Hospital, Monmouth, Illinois 61462 (309) 734-3141.

**PHYSICIAN WANTED:** Family Practitioner, Board Eligible or Certified, full time position. Chicago suburban group with complete diagnostic facilities. Excellent starting compensation. Profit sharing and pension program. Pleasant working conditions. Capable interested medical associates. Convenient location, regular hours, good hospital affiliation, vacations. Insurance benefits include life, hospitalization, catastrophic medical expense, disability and malpractice. Medical Society and hospital dues paid by corporation. Call collect: Eugene J. Scherba, M.D., or Administrator, Thomsen Clinic, Ltd. (312) B49-2400.

**CARBONDALE:** General Practitioner, Family Practitioner or Internist —for health service at prominent university which includes a school of medicine. Scenic recreational area combining the virtues of small town living with the cultural and shopping assets of a large metropolitan area. Attractive salary, 40-hour work week and generous fringe benefits. IL license required. A.A.E.O. employer. For further information send vitae to Don Knapp, M.D., Medical Director, SIU-C Health Service, Carbondale, IL 62901.

**PHYSICIAN WANTED** for a private west suburban clinic with some industrial work. Attractive starting salary and early partnership. Call (312) 449-6600, ask for Mrs. McLennan.

**ORTHOPEDIC SURGEON** who desires to locate in a rural area of southern Illinois needed to serve two community hospitals. One hour from St. Louis. Good educational system for children. Excellent recreation. Reply: T. K. Janssen, Administrator, Washington County Hospital, Nashville, Illinois 62263.

**WANTED—M.D.,** certified Family Practice, To direct and establish Family Practice Residency. Please reply to Box 927, c/o IMJ, 55 E. Monroe, Suite 3510, Chicago, 60603.

**ENT SPECIALIST** needed in a large, fast growing Chicago suburb. No other ENT specialist in town. Very favorable terms. Send resume to Box 926, c/o IMJ, 55 E. Monroe, Chicago, Illinois 60603.

**CHICAGO AREA—PSYCHIATRIST**—Board certified or board eligible, licensed to practice in Illinois. Part-time position (21 hours) with well established outpatient mental health clinic in south suburban Cook County. Psychiatric services include diagnosis and treatment of precare and aftercare patients, staff training and development, community consultation and educational efforts. Fringe benefits include sick leave, vacation and retirement program. Contact Carolyn T. Cochrane, Ph.D., acting exec. dir., or Robert E. Drom, M.D., med. dir., Family Service and Mental Health Center of South Cook County, 1240 Ashland Avenue, Chicago Heights, IL 60411; (312) 755-2250.

**DERMATOLOGIST** needed for a large, fast growing Chicago suburb. Solo practice. Ideal for a second office. Office space available in a new medical complex. Very favorable terms. Send resume to Box 92B, c/o IMJ, 55 E. Monroe, Chicago, Illinois 60603.

**OVERHEAD MOUNTING? WORKING LONG HOURS?** Consider working in a University Health Service. 40 hour week—positive fringe benefits including generous vacation times. Illinois license. Equal opportunity/affirmative action employer. Contact: M. M. Torray, M.D., Illinois State University, Normal, Illinois 61761. Tel.: 309-43B-B655.

**PHYSICIAN WANTED:** Internist, board certified, full time to join Chicago suburban group with complete diagnostic facilities. Excellent starting compensation, profit sharing and pension program. Pleasant working conditions. Capable, interested medical associates. Convenient location, regular hours and good hospital affiliations, vacations. Insurance benefits include Life, Hospitalization, Catastrophic Medical Expense, Disability for Illness and Accident and Malpractice. Medical society and hospital dues paid by corporation. Call collect: Eugene J. Scherba, M.D. or Administrator, Thomsen Clinic, Ltd. (312) B49-2400.

**MATTOON—CHARLESTON, ILLINOIS.** Sara Bush Lincoln Health Center Emergency Department has July opening for qualified physician. Guarantee $50,000-$55,000 with ideal working conditions and schedule. Send curriculum vitae to Stephen Allin, M.D., Emergency Department Director, P.O. Box 372, Mattoon, Illinois 6193B or call toll free 1-800-325-39B2 for details.

## FOR SALE, LEASE OR RENT

**MEDICAL OFFICE SUITE FOR RENT,** Lincoln-Belmont Bldg. 715-1200 square feet, available at once in full service, elevator, active professional building. Call Gary Solomon, (312) 334-5400.

**MEDICAL CENTER FOR RENT.** Complete and ready to open. 4300 sq. ft. at 2301 E. 95th Street, Chicago. Large waiting rm., 1B exam rms., x-ray rm., central a/c & heat. Call Gary Solomon, (312) 334-5400.

**SUITE TO LEASE** for Internist, Pediatrician, Psychologist, Psychiatrist or other medical practice. Suite is located in a high quality building with a growing medical community situated across from a major hospital. The complex already includes an outstanding lab, X-ray facility, pharmacy and 16 professionals. Arrangement provides flexibility for the new tenant to share a suite with an existing practice, to have office built in newly created bare space and to participate in the ownership and direction of the complex. STRONG Property Managers, Ltd. Agents, 201 W. Springfield, Champaign, IL 61B20. (217) 356-2617.

**DENTIST** looking to share office space with doctors—Northwest Suburbs or Northside Chicago. Will rent new space together or join in your existing location. Please call 312-729-1851.

**SPACIOUS** Northside Lakeview area medical office for rent. Newly remodeled. Five examining rooms, carpeted. Large furnished waiting room. Available now. Interested in Spanish speaking doctors only. Growing Spanish speaking area. Near Ashland-Lincoln and Belmont. Pharmacy space also availble, if desired. Please contact: Dr. Pedro O. Cabrera (Dentist) at 1442 W. Belmont or call (312) 52B-0068.

**NAPLES, FLORIDA,** apartment, 2 bedroom, kitchen, good equipment, pool, nice location. $2,500 winter season (3 to 4 months). Off season $350 to $500/mo. Available anytime except December 15 to January 10. Call (203) 233-5554.

**CAPE COD: FALMOUTH.** For sale. Doctor's home and five-room adjoining office suite. Separate parking and entrances. Handsome wood-shingle contemporary sits high on knoll of wooded acre overlooking harbor. Quiet and private neighborhood of fine homes. Good investment properties. Office rental currently $4,500. Widow selling. Harold Bach, R.E. (617) 540-0707.

**MEDICAL BUILDING**—Take over thriving family practice, 40 years high volume, $155,000 gross. 2500 sq. ft. includes large waiting room, X ray/darkroom, examining room, surgery, reception, office, 2 bathrooms, drug facilities, various equipment. Additional space for associates or offices, air conditioned, two hospitals ten minutes away. Located in Oak Lawn, southwest Chicago suburb. (312) 422-0222.

## SITUATIONS WANTED

**EXPERIENCED ER PHYSICIAN** wants to join emergency room hospital group in permanent ER position. Please write 8ox 910, c/o IMJ, 55 E. Monroe, Suite 3510, Chicago, 60603.

**RADIOLOGIST** seeks permanent part-time position, 4 hrs/day, fluroscopy and/or film reading. Chicago metropolitan area. Please write 8ox 911, c/o IMJ, 55 E. Monroe, Suite 3510, Chicago, IL 60603.

**DIAGNOSTIC RADIOLOGY**—8oard eligible. Well trained in ultrasound, CAT scan. Part or full time. Also for film reading. Call (312) 771-8076.

**CERTIFIED PHYSICIAN'S ASSISTANT IN MEDICINE:** Experienced and willing to learn, will relocate. Masood, 1260 West Bryn Mawr, Chicago, 60660. Telephone: 312-649-4561 (days) 769-4686 or 690-0544 (evenings).

**DR. P. J. REDDY**—Male, 39 years—Psychiatry, M.D., D.P.M., F.R.C.P.(C), ABPN, with total ten years of wide experience in Psychiatry with Illinois license looking for place in private practice or a salaried job.

**DR. P. V. REDDY**—Female, 34 years—OB-GYN, M.D., M.R.C.O.G. (U.K.), American 8oard Certified with Illinois license. Total ten years in O8-GYN. Looking for place in private practice or a salaried job. Please contact Dr. P. J. Reddy, Union Hospital, Moose Jaw, Saskatchewan, Canada. Office—(306) 692-1B41; Home—(306) 693-32BB.

## GUARANTY FUND CERTIFICATE

**GUARANTY FUND CERTIFICATE** issued by the Illinois State Medical Inter-Insurance Exchange for sale. Coverage $100,000/$300,000. Class 5, Specialty: Otorhinolaryngology. Original purchase price $6,840.00. Interested: Contact Olawale O. Idewu, M.D. 9204 South Commercial Avenue, Chicago, Illinois 60617; Tel. (312) 735-8033 or 734-4243.

**GUARANTY FUND CERTIFICATE:** Class 4, Territory 1 for $1 Million/$1 Million. Moving out of state. Purchase price $2572 in 1976. Please reply to Box 921, c/o IMJ, 55 E. Monroe, Suite 3510, Chicago 60603.

**ILLINOIS STATE MEDICAL INTER-INSURANCE EXCHANGE GUARANTY FUND CERTIFICATE.** For sale leaving Illinois—relocating. Medical specialty Anesthesiology, Class 5. $1 Million/$1 Million coverage, purchase price $10,000, Policy No. 204199. Favorable arrangements can be made. Send inquiries to 8ox 922, c/o IMJ, 55 East Monroe, Suite 3510, Chicago, 60603.

**ISMIE GUARANTY FUND CERTIFICATE:** Price (original) $6024.00. Specialty: OB-GYN, Class V, Territory II. Have moved out of Illinois. Discount price. Will be available, Thomas T.H. Lin, M.D. 175 N. Jackson Ave., Suite 20B, San Jose, CA 95116, (40B) 251-5205.

**GUARANTY FUND CERTIFICATE:** Class 8 Inter-Insurance Exchange Certificate for sale (previously class 5). Call 266-1977, 9-5 P.M.

**ILLINOIS STATE MEDICAL INTER-INSURANCE EXCHANGE** Guaranty Fund Certificate #1160 Territory II Class 5 (1 mil/1 mil) OB-GYN for sale. Orig. price $6024. 8est offer. Left state. Contact. M. Hosseinipour, M.D., c/o P.O. Box 6B1, Williamson, W.Va. 25661. (606) 237-1020 or 237-1083.

**GUARANTY FUND CERTIFICATE** for sale at discount. Phone (312) 579-0133.

**ILLINOIS STATE MEDICAL INTER-INSURANCE EXCHANGE** Guaranty Fund Certificate for sale. Territory 1 Class 1—Purchase price $772. 8est offer. Please contact Mrs. Burton at 388-8052.

**FOR SALE:** I.S.M.I.E. Guaranty Fund Certificate, Class 5, value $6400. Negotiable, (217) 544-7479.

**GUARANTY FUND CERTIFICATE,** ISMIE, Territory I, Class I G.P. Cost $772. Will sell $672. Phone Dr. Cheng (312) 848-9000.

**GUARANTY FUND CERTIFICATE** issued by the Illinois State Medical Inter-Insurance Exchange for sale. Coverage $100,000/$300,000. Original purchase price $6,024.00. Interested call (312) 963-B777 or 920-8792.

## GUARANTY FUND CERTIFICATE WANTED

**GUARANTY FUND CERTIFICATE** Wanted to purchase—Guaranty Fund Certificates for the Illinois State Medical Inter-Insurance Exchange—call (312) 423-4499.

*IMJ and ISMS are not acting as brokers or agents; this is provided as a membership service.*


**RAVENSWOOD HOSPITAL MEDICAL CENTER**

**Primary Care: A View Toward the 80's**

*A 15-hour C.M.E. Credit Conference on the present and future directions of primary care medicine featuring discussions, lectures and case conferences on relevant primary care topics.*

For: Internists, Pediatricians, Family Practitioners.

August 17, 18, 19, 1978
A.M. SESSIONS ONLY

Interlaken Resort Lodge/Villas
Lake Geneva, Wisconsin

For further information, contact
Dept. of Medical Education
Ravenswood Hospital Medical Center
4550 N. Winchester at Wilson
Chicago, Illinois 60640
(312) 878-4300, Ext. 343

Travel Medical Seminar for all Members and Families of

# ILLINOIS STATE MEDICAL SOCIETY

# Eastern Mediterranean

## Air/Sea Cruise





**DEPARTING CHICAGO—OCTOBER 25, RETURNING NOVEMBER 7, 19**

### Sail from Athens to Turkey, Egypt, Israel and the Greek Isles.

Discover democracy's symbolic birthplace in Athens . . . biblical Ephesus a great architectural wonder . . . exotic Istanbul filled with mosques, minarets and bright bazaars . . . charming Mykonos and intriguing Crete, both unforgettable.

Visit Alexandria, gateway to Cairo, Egypt's city of the Sphinx and Pyramids . . . Haifa, entrance to the biblical city of Jerusalem . . . and Rhodes with its idyllic landscape.

Your ship will be prestigious Sun Line's flagship, the SS STELLA SOLARIS that is nothing less than elegant. The staterooms are spacious, lounges are decorated with soft velvet and genuine leather. The dining room is comfortably large offering tables set with fine crystal, monogrammed china and fresh flowers.

There's even more. Energetic deck games, two swimming pools, sauna and gymnasium. Restful lounges, a library and sunny promenades for relaxing. Fine evening entertainment, first-run movies an deserted moonlit decks.

Come sail the sun-sparkled Mediterranean with us for tw weeks. From as low as $159 enjoy round-trip flights with 70 pound luggage allowanc spacious accommodations aboard ship, three superb meals each day plus mid-morning bouillon and late ni buffet, transfers, INTRAV Trav Director and Cruise Director.

A Non-Regimented
**INTRAV®**
Deluxe Adventure

**Send to:** **Illinois State Medical Society**
**55 East Monroe**
**Chicago, Illinois 60603**

Enclosed is my check for $ _____ ($100 per person) as deposit.

Names _____

Address _____

City _____ State _____ Zip _____

Area Code _____ Phone _____

Space Strictly Limited—Make Reservations Now

# View Box

*(Continued from page 431)*

**Diagnosis:**

*(2) Foramen of Morgagni Hernia*

A right cardiophrenic angle mass on the frontal view obliterates the inferior right heart border and is confirmed as being anterior on the lateral view (Figure 1). All diagnoses listed should be considered when examining a mass in this location. In this case, however, the mass is not homogenous but contains multiple lucencies. A pericardial cyst and epicardial fat would be homogenous. Rarely a neoplasm could be necrotic, but the lateral view shows the gas in the mass extending into the abdomen.

The barium-filled colon extends into the hernia and gas-filled small bowel and lies adjacent to the colon on a lateral view of a barium enema (Fig. 2). Congenital diaphragmatic hernias occur through:

(1) partial or complete absence of the diaphragm (rare);
(2) defects of posterior pleuroperitoneal membrane—Foramen of Bochdalek hernia;
(3) parasternal defects—Foramen of Morgagni hernia;
(4) eventration—failure of diaphragmatic muscle development;
(5) defect septum transversum with hernia into pericardium—(very rare);
(6) defects of esophageal hiatus.

The Foramina of Morgagni are small triangular areas of the diaphragm adjacent to the inferior sternum which transmit the epigastric vessels. They are bounded medially by muscle fibers from the xiphoid and laterally by muscle fibers from costal cartilages. Morgagni hernias are almost always on the right and usually don't become evident until late childhood or adulthood. When present in childhood they often contain liver. In the adult they are most often empty or contain only omentum. In a small percentage of cases, the hernia contains small bowel, colon or even stomach if the hernia gets big enough. The patient is usually asymptomatic but may have pain, cough, or dyspnea. Obstruction has occurred rarely after incarceration of the stomach. Posterior, Foramen of Bochdalek hernias and esophageal hiatus hernias are both 10-20 times as common as Morgagni hernias.

This diagnosis should be considered in patients with right cardiophrenic angle masses. Plain film diagnosis can be made if bowel gas is identified as in this case, or if properitoneal fat is seen entering the mass on the lateral view. Lucencies can be confirmed as bowel gas with barium studies. If none of these findings are present, pneumoperitoneum will result in air entering the mass, which proves connection with the abdominal cavity.

**References**

Gray, S. W., and Skandalakis, J. E.: Embryology for Surgeons, W. B. Saunders, Philadelphia, 1972.

Nyhus, L. M., and Harkins, H. N.: Hernia, J. B. Lipincott, Philadelphia, 1964.

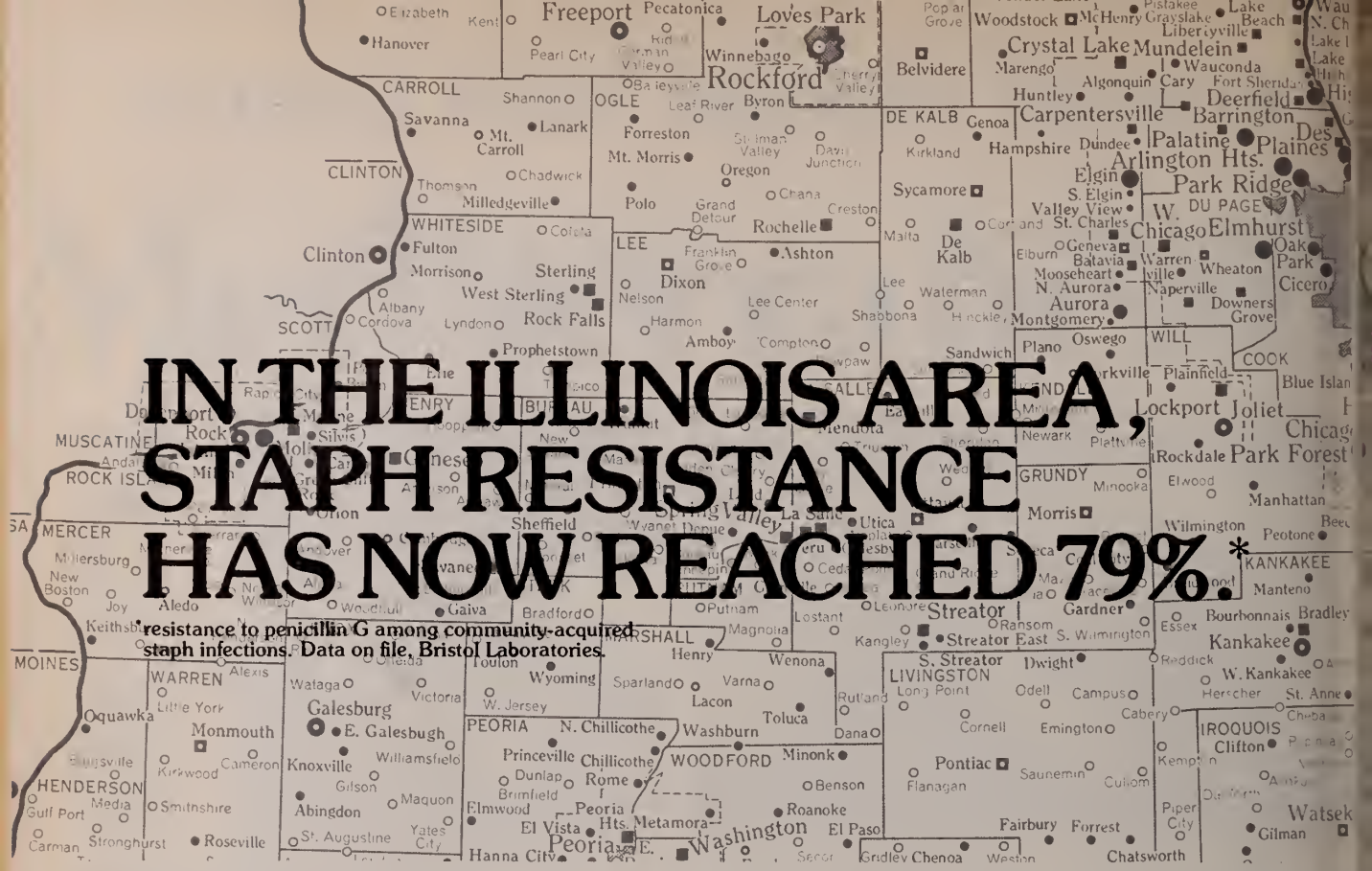
**AMERICAN INTERNATIONAL HOSPITAL**

Robert S. Mendelsohn, M.D., Medical Director
is seeking qualified physicians in:

**General Practice**
**Osteopathic Medicine**
**Cardiology**
**Obstetrics/Gynecology**
**Medical Oncology**
**Pediatrics**
**General Surgery**
**Other selected specialties**

Reply in confidence to:

**Kenneth A. Marcoux, MBA, MHA**
**American International Hospital**
Zion, Illinois 60099
312/872-4561




# IN THE ILLINOIS AREA, STAPH RESISTANCE HAS NOW REACHED 79%.*

*resistance to penicillin G among community-acquired staph infections. Data on file, Bristol Laboratories.

## WHEN YOU CAN'T RULE OUT STAPH, CONSID

# TEGOPEN®
# (cloxacillin sodium)

## ...THE PENICILLIN OF TODAY"

- Effective against nonpenicillinase-producing staphylococci, beta-hemolytic streptococci, and pneumococci.†

†NOTE: The choice of Tegopen should take into consideration the fact that it has been shown to be effective only in the treatment of infections caused by pneumococci, Group A beta-hemolytic streptococci, and penicillin G-resistant and penicillin G-sensitive staphylococci. If the bacteriology report later indicates that the infection is due to an organism other than a penicillin G-resistant staphylococcus sensitive to cloxacillin sodium, the physician is advised to continue therapy with a drug other than cloxacillin sodium or any other penicillinase-resistant semisynthetic penicillin. The clinical significance of *in vitro* data is unknown.

- 10 times more active against strep than staph.

- Well absorbed from the G.I. tract.‡

‡Maximum absorption occurs when Tegopen is taken on an empty stomach, preferably 1-2 hrs. before meals.



Please see brief summary for prescribing information

**Brief Summary of Prescribing Information**
**Combined TEGOPEN®** (cloxacillin sodium)
**Capsules and Oral Solution**
For complete information, consult Official Package Circular. (12) TEGOPEN 9/11/75

**Indications:** Although the principal indication for cloxacillin sodium is in the treatment of infections due to penicillinase-producing staphylococci, it may be used to initiate therapy in such patients in whom a staphylococcal infection is suspected. (See Important Note below.)

Bacteriologic studies to determine the causative organisms and their sensitivity to cloxacillin sodium should be performed.

**Important Note:** When it is judged necessary that treatment be initiated before definitive culture and sensitivity results are known, the choice of cloxacillin sodium should take into consideration the fact that it has been shown to be effective only in the treatment of infections caused by pneumococci, Group A beta-hemolytic streptococci, and penicillin G-resistant and penicillin G-sensitive staphylococci. If the bacteriology report later indicates the infection is due to an organism other than a penicillin G-resistant staphylococcus sensitive to cloxacillin sodium, the physician is advised to continue therapy with a drug other than cloxacillin sodium or any other penicillinase-resistant semi-synthetic penicillin.

Recent studies have reported that the percentage of staphylococcal isolates resistant to penicillin G outside the hospital is increasing, approximating the high percentage of resistant staphylococcal isolates found in the hospital. For this reason, it is recommended that a penicillinase-resistant penicillin be used as initial therapy for any suspected staphylococcal infection until culture and sensitivity results are known.

Cloxacillin sodium is a compound that acts through a mechanism similar to that of methicillin against penicillin G-resistant staphylococci. Strains of staphylococci resistant to methicillin have existed in nature and it is known that the number of these strains reported has been increasing. Such strains of staphylococci have been capable of producing serious disease, in some instances resulting in fatality. Because of this, there is concern that widespread use of the penicillinase-resistant penicillins may result in the appearance of an increasing number of staphylococcal strains which are resistant to these penicillins.

Methicillin-resistant strains are almost always resistant to all other penicillinase-resistant penicillins (cross-resistance with cephalosporin derivatives also occurs frequently). Resistance to any penicillinase-resistant penicillin should be interpreted as evidence of clinical resistance to all, in spite of the fact that minor variations in *in vitro* sensitivity may be encountered when more than one penicillinase-resistant penicillin is tested against the same strain of staphylococcus.

**Contraindications:** A history of a previous hypersensitivity reaction to any of the penicillins is a contraindication.

**Warning:** Serious and occasionally fatal hypersensitivity (anaphylactoid) reactions have been reported in patients on penicillin therapy. Although anaphylaxis is more frequent following parenteral therapy it has occurred in patients on oral penicillins. These reactions are more apt to occur in individuals with a history of sensitivity to multiple allergens.

There have been well documented reports of individuals with a history of penicillin hypersensitivity reactions who have experienced severe hypersensitivity reactions when treated with a cephalosporin. Before therapy with a penicillin, careful inquiry should be made concerning previous hypersensitivity reactions to penicillins, cephalosporins, and other allergens. If an allergic reaction occurs, the drug should be discontinued and the patient treated with the usual agents, e.g., pressor amines, antihistamines, and corticosteroids.

Safety for use in pregnancy has not been established.

**Precautions:** The possibility of the occurrence of superinfections with mycotic organisms or other pathogens should be kept in mind when using this compound, as with other antibiotics. If superinfection occurs during therapy, appropriate measures should be taken.

As with any potent drug, periodic assessment of organ system function, including renal, hepatic, and hematopoietic, should be made during long-term therapy.

**Adverse Reactions:** Gastrointestinal disturbances, such as nausea, epigastric discomfort, flatulence, and loose stools, have been noted by some patients. Mildly elevated SGOT levels (less than 100 units) have been reported in a few patients for whom pretherapeutic determinations were not made. Skin rashes and allergic symptoms, including wheezing and sneezing, have occasionally been encountered. Eosinophilia, with or without overt allergic manifestations, has been noted in some patients during therapy.

**Usual Dosage:** Adults: 250 mg. q.6h.

Children: 50 mg./Kg./day in equally divided doses q.6h. Children weighing more than 20 Kg. should be given the adult dose. Administer on empty stomach for maximum absorption.

*N.B.:* INFECTIONS CAUSED BY GROUP A BETA-HEMOLYTIC STREPTOCOCCI SHOULD BE TREATED FOR AT LEAST 10 DAYS TO HELP PREVENT THE OCCURRENCE OF ACUTE RHEUMATIC FEVER OR ACUTE GLOMERULONEPHRITIS.

**Supplied:** Capsules—250 mg. in bottles of 100, 500 mg. in bottles of 100. Oral Solution—125 mg./5 ml. in 100 ml. and 200 ml. bottles.

BRISTOL®
BRISTOL LABORATORIES
Division of Bristol-Myers Company
Syracuse, New York 13201

# *Obituaries*

**°°Apple, Carl,** St. Paul, Minnesota, died April 22, 1978, at the age of 83. Dr. Apple, formerly of Chicago was a 1923 graduate of the University of Illinois School of Medicine. Before his retirement in 1973, he was on the staff of Mt. Sinai and Edgewater Hospitals.

**Austin, Bruce,** Schaumburg, died October 1, 1977, at the age of 70. Dr. Austin was a 1932 graduate of the University of Nebraska College of Medicine.

**°Fahey, John Robert,** Mundelein, died September, 1977, at the age of 60. Dr. Fahey was a 1950 graduate of the Loyola University Stritch School of Medicine.

**°Grant, Harry E.,** Springfield, died May 9, 1978, at the age of 61. Dr. Grant was a 1942 graduate of Northwestern University Medical School.

**°Hill, Elizabeth,** Evanston, died May 3, 1978, at the age of 80. Dr. Hill followed her 1931 graduation from the University of Illinois with many achievements in medicine and community interests. Dr. Hill was chief of the medical staff of Community Hospital, Evanston, and emeritus staff member of Evanston Hospital. In 1946 Dr. Hill was honored as woman of the year by the Evanston Business and Professional Women's Club.

**°Kay, Marie B.,** Prospect Heights, died April 24, 1978, at the age of 64. Dr. Kay was a 1945 graduate of Stritch School of Medicine and was a staff member of Holy Family Hospital in DesPlaines and St. Mary of Nazarath Hospital, Chicago.

**°Lippert, Jerome H.,** Chicago, died April 24, 1978, at the age of 64. A 1940 graduate of the Chicago Medical School, he was president-elect of the Illinois Society of Allergy.

**Nisbet, Robin W.,** Chicago, died October 12, 1977, at the age of 26. Dr. Nisbet was a graduate of the University of Illinois School of Medicine.

**°Rimke, Sofia,** Chicago, died October 22, 1977, at the age of 56. Dr. Rimke was a 1950 graduate of the University of Bayeru, Germany.

**°°Zakon, Samuel J.,** Chicago, died May 17, 1978, at the age of 79. In 1925 he graduated from the Eclectic Medical School in Cincinnati, Ohio. Among his accomplishments, Dr. Zakon was professor emeritus of dermatology at Northwestern University School of Medicine and First Historian of the American Academy of Dermatology.

Dr. Zakon also was former president of the medical staff at Mt. Sinai Medical Center and also of the Chicago Dermatological Society.

*°Indicates ISMS member.*
*°°Indicates member of the ISMS Fifty Year Club.*

# COLBY PROCLAIMS WOMAN SUFFRAGE

Signs Certificate of Ratification at His Home Without Women Witnesses.

MILITANTS VEXED AT PRIVACY.

Wanted Movies of Ceremony, But Both Factions Are

WASHINGTON, Aug. 26, 1920—




# Social Security Bill Is Signed Gives Pensions to Aged, Jobl

## Roosevelt Approves Message Intended to Benefit 30,0 Persons When States Adopt Cooperating Laws—He the Measure 'Cornerstone' of His Economic Progr

WASHINGTON, Aug. 1
The Social Security Bill, a broad program of unemp insurance and old age and counted upon to ben 20,000,000 persons, becam day when it was signed dent Roosevelt in the pr those chiefly responsible ting it through Co

Mr. Roosevelt cal "the cornerstone which is being me s c

# SENATE APPROVES 18-YEAR OLD VOTE IN ALL ELECTIONS

Amendment to Constitution is Sent to House, Where Passage is Expected

WASHINGTON, March 10, 1971—The Senate approved today, 94 to 0, and sen

# TRUMAN CLOSES TED NATIONS CONFEREN TH PLEA TO TRANSLATE CHARTER INTO DEEDS

## NEW WORLD HOPE

President Hails 'Great Instrument of Peace,' Insists It Be Used

## HISTORIC LANDMARK

Meeting Gives Standing Ovation as Executive Pictures Peace Gain

"If we fail to use it," he declared to the solemn final meeting of the delegates, 'we shall betray all of those who have died in order that we might meet here in freedom and safety to create it.'

"If we seek to use it selfishly—for the advantage of any one nation or any small group of nations—we shall be equally guilty of that betrayal."

Fervent Interpolation

The President, speaking in the auditorium of the War Memorial Opera House, built in memory of sons of the Golden Gate city who gave their lives in the first World War, in which he himself served, seemed to give unconscious expression to the solemn feeling of the occasion when, at the outset of his speech, he interpolated the words, half a hope, half a prayer:

"Oh, what a great day this can be in history!"

# OUL SIGNI the Draf Ends No

WASHINGTON, Jan. 27, 1973—"With the signing of the peace agreement in Paris today, and after receiving a report from the



# PATIENT PACKAGE INSERTS: A CONCEPT WHOSE TIME HAS COME?

*The consumer's right to know is an irreversible and desirable trend of the Seventies. It extends, and properly, to a patient's right to know more about his or her prescription medications. One way, gaining favor, is through patient package inserts. Wisely-prepared and properly distributed when medically indicated, they could markedly improve patient knowledge and drug therapy—laudable goals by anyone's standards.*

*The PMA endorses these goals and will work with government, the health professions and consumers to achieve them.*

## The Advantages

The concept holds promise of benefits: better patient understanding of the product prescribed, better adherence to the treatment plan, and more awareness of possible side reactions.

Every doctor has had patients who fail to finish antibiotic regimens because they feel better. Some patients assume that if one tranquilizer or analgesic is good, two may be twice as good. Still others fail to report dizziness while on antihypertensive therapy—and so on.

Problems like these might arise less often if the patient received written information in addition to verbal instructions. Some studies suggest that patients are more receptive to such materials, and they more often understand the verbal instructions and follow them, when inserts are used.

## The Disadvantages

There are also some potential problems. Obviously, the inserts must be clearly phrased, without extraneous or complex detail. How much information is enough? How can it be kept current? Should all patients receive the same information? Should inserts be included with all drugs? Should only potential problems be listed or are patients better off with a "fair balance" presentation that describes usefulness as well as drawbacks?

These and similar questions require answers, since model inserts have yet to be properly developed and tested. Despite the need for these studies, the FDA is proceeding prematurely with inserts on selected products. We think the Congress is the only place where the matter can be given the proper legal status and direction, particularly since it represents a conceptual change in the legal, medical and social framework of the nation's prescription drug information system.

## The Solution

The PMA believes that carefully-devised pilot studies of various kinds of inserts are needed. They should be developed and implemented with full participation by doctors, pharmacists, consumers, communications experts and the drug industry. Such studies will provide reliable pathways to follow, so that inserts will be useful aids to medical practice.

And particularly we think that you should be closely involved in this debate and in these studies and decisions. Otherwise, people with less experience and qualifications may control the purposes, content and use of a tool with considerable promise for improved patient care. It could make a difference in your practice tomorrow, and more importantly, in the health of your patients.

PMA
THE PHARMACEUTICAL MANUFACTURERS ASSOCIATION
1155 FIFTEENTH ST., N. W., WASHINGTON, D. C. 20005

# Pulse of the ISMS Auxiliary

*(Continued from page 467)*

Edition, which has a circulation of over 1,245,-800. A reminder of our medical community's contribution to the quality of life in Illinois during the last half-century would be both interesting and educational. Any profits would be contributed to the benevolence fund.

A survey is in progress to determine our members' wishes concerning this ambitious project. Members wishing to further this cause are requested to list all possible subscribers in their areas, and forward them to executive secretary Jane Swanson.

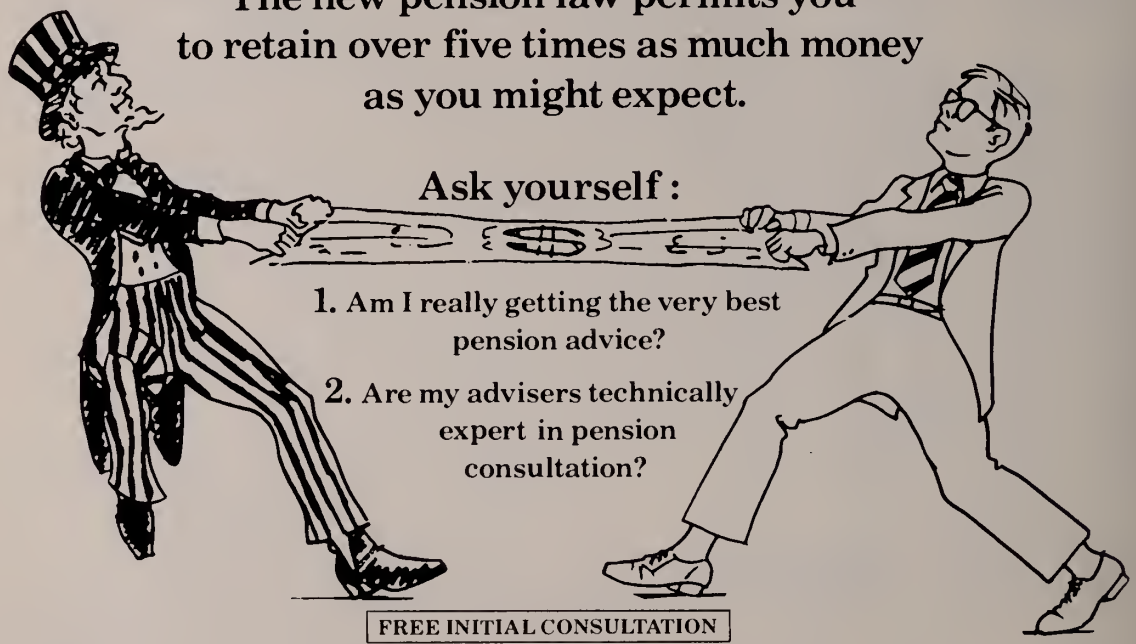
Two fall conferences are in the planning stage, and will replace the usual district meetings as suggested by last season's participants. Members are urged to attend both, as they will differ in format. Reports will be given at both conferences by delegates attending the AMA auxiliary convention, June 18-21 in St. Louis.

Fall conference—north will be held in late September at the Lincolnshire Marriott Motel near O'Hare Airport. A communications workshop, with instructions on microphone technique, fielding unfriendly questions from the press, and general public speaking will be one feature of this conference. Speakers will cover CPR, immunization, project bank and package programs, nutrition and the impaired physician. Representative Adeline Geokaris of the 31st congressional district, candidate for the Illinois senate, will address this gathering.

Fall conference—south will take place in Belleville, Illinois near St. Louis airport. The Ramada Inn near 164 and the new St. Clair Square will house this meeting. A Board meeting and dinner are scheduled for November 8th. The regular conference will begin at 9 a.m., November 9th, and will feature reports from leadership confluence held in Chicago, October 25-28. The future county presidents privileged to attend will share the wide range of knowledge and expertise gained at those remarkable training sessions.

So our garden grows in Illinois. It should continue to flourish if aided by a rich mixture of planning, tending and cultivation through membership interest, support and cooperation.


**The new pension law permits you to retain over five times as much money as you might expect.**




FREE INITIAL CONSULTATION

American Society Pension Actuaries

Consultants to the Chicago Medical Society Employees Pension Plan

National Association Pension Consultants

Mann, Levine & Weiss, Ltd. 3525 W. Peterson, Chicago, IL 60659

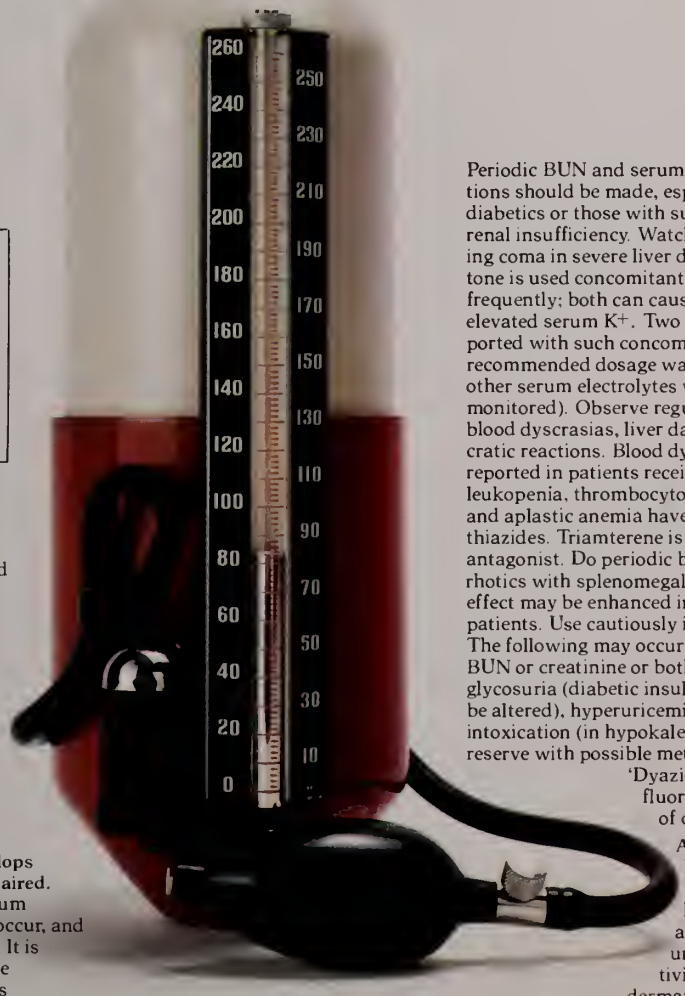
(312) 539-7820 Pension Consultants and Plan Designers (312) 539-7820

# TRIAMTERENE CONSERVES POTASSIUM WHILE HYDROCHLOROTHIAZIDE LOWERS BLOOD PRESSURE

# DYAZIDE®

Each capsule contains 50 mg. of Dyrenium® (triamterene, SK&F Co.) and 25 mg. of hydrochlorothiazide.

## MAKES SENSE




Before prescribing, see complete prescribing information in SK&F Co. literature or PDR. A brief summary follows:

* **Warning**
This drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual. If this combination represents the dosage so determined, its use may be more convenient in patient management. Treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

* **Indications:** When the combination represents the dosage determined by titration: Adjunctive therapy in edema associated with congestive heart failure, hepatic cirrhosis, the nephrotic syndrome. Corticosteroid and estrogen-induced edema, idiopathic edema; hypertension, when the potassium sparing action of triamterene is warranted. (See Box Warning.) Routine use of diuretics in healthy pregnant women is inappropriate; they are indicated in pregnancy only when edema is due to pathological causes.

**Contraindications:** Further use in anuria, progressive renal or hepatic dysfunction, hyperkalemia. Pre-existing elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs.

**Warnings: Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired.** If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in the severely ill, with urine volume less than one liter/day, the elderly and diabetics with suspected or confirmed renal insufficiency. Periodically, serum $K^+$ levels should be determined. If hyperkalemia develops, substitute a thiazide alone, restrict $K^+$ intake. **Associated widened QRS complex or arrhythmia requires prompt additional therapy.** Thiazides cross the placental barrier and appear in cord blood. Use in pregnancy requires weighing anticipated benefits against possible hazards, including fetal or neonatal jaundice, thrombocytopenia, other adverse reactions seen in adults. Thiazides appear and triamterene may appear in breast milk. If their use is essential, the patient should stop nursing. Adequate information on use in children is not available.

**Precautions:** Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Watch for signs of impending coma in severe liver disease. If spironolactone is used concomitantly, determine serum $K^+$ frequently; both can cause $K^+$ retention and elevated serum $K^+$. Two deaths have been reported with such concomitant therapy (in one, recommended dosage was exceeded, in the other serum electrolytes were not properly monitored). Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with thiazides. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effect may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine.

**Adverse Reactions:** Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances. Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and, rarely, allergic pneumonitis have occurred with thiazides alone.

**Supplied:** Bottles of 100 and 1000 capsules; Single Unit Packages of 100 (intended for institutional use only).

**FOR LONG-TERM CONTROL OF HYPERTENSION.* SERUM $K^+$ AND BUN SHOULD BE CHECKED PERIODICALLY. (SEE WARNINGS SECTION.)**

SK&F CO., Carolina, P.R. 00630

**SK&F CO.**
a SmithKline company

## *President's Page*



# A New Look

When the AMA House of Delegates meets this month in St. Louis, it will feature a "new look." The group debating the controversial Report of the National Commission on the Cost of Medical Care will include delegates elected by specialty societies.

Groundwork for this new structure was laid last year amid much controversy. At that time, the House altered the function of its specialty section councils and provided for direct representation of large specialty *societies*. Opponents argued that some physicians now would be the beneficiaries of "double representation"—through their state as well as specialty society. Conceding some validity to that viewpoint, I believe the benefits of direct representation far outweigh any liabilities.

Undeniably, medicine's effectiveness is damaged when it exhibits a fragmented response to major challenges. Direct specialty society representation in the AMA House should prevent fragmentation.

Meanwhile, other important segments of our profession are increasing their participation. Year-end AMA membership includes 13,500 residents and 14,000 students—nearly 14 percent of the Association's total. In addition to representation in the House of Delegates, residents have a voting member on seven of the eight AMA councils . . . while the students have a voice on five councils and a vote on one.

The large number of resident and student members and the new role of specialty societies are significant. These developments dramatically refute the often-leveled charge that the AMA is a purely "establishment" organization.

The views of all segments of medicine are vital to the debate on cost containment and they can be heard in the AMA House of Delegates.

David S. Fox, M.D., President

# Doctor's News

**LICENSE RENEWAL DEADLINE**—July 1 is the deadline for physicians to renew their Illinois licenses. Applications were distributed by the Department of Registration and Education during the first week of May, but the postal service has returned over 2,000 applications for lack of a correct address. If you have not received a renewal application, contact R&E at 628 E. Adams, Springfield, 62786, (217-782-7935).

Licenses not renewed before July 1 will be considered lapsed, and continued medical practice under this circumstance raises some legal questions. In addition, some questions have been raised as to whether liability insurance will cover activities during the period when a license is lapsed. The fee for renewal is $40. Renewals received after July 1, however, require a fee of $60.

The renewal form calls for an indication of required continuing medical education. For this renewal, 12 hours are needed, and four of these must be in Category 1. They may have been earned during the 21 month period July 1, 1976 through March 31, 1978. If an applicant checks non-compliance, a statement of explanation must be attached to the application.

**ISMS CALLS FOR CONSUMER PROTECTION**—ISMS President David S. Fox, M.D., recently called for development of a mechanism to monitor cost savings under the new Illinois generic drug substitution law, as required in the statute.

The generic drug law takes effect July 1, 1978. It requires IDPH to assess consumer savings and report back to the Illinois legislature. A positive formulary has been distributed, but, said Doctor Fox, these do not guarantee savings to the consumer.

While the law permits substitution only when the generic drug is less costly than a prescribed brand name and is on the formulary and the patient consents, it does not require that all savings be passed on to the patient. In fact, Doctor Fox said, the lack of safeguards could result in higher costs. He cited an experimental drug interchange program which was dropped because no significant cost reduction was effected.

For more information on the new law, please see story on page 440.

**SPECIAL AWARD**—The Illinois Society of Internal Medicine has received the Component Society Newsletter Merit Award from the American Society of Internal Medicine. The quarterly newsletter is edited by Donald H. Hanscom, M.D., Hinsdale.

**RUSH RECEIVES MAXIMUM ACCREDITATION**—Rush University has been granted ten-year accreditation by the North Central Association of Colleges and Schools (NCA). Rush is among more than 800 post-secondary institutions and 4300 schools accredited through the 19-state NCA. The accreditation pertains to the academic component of Rush-Presbyterian-St. Luke's Medical Center, comprising Rush Medical College and the colleges of Nursing and Health Sciences.

**DR. AND MRS. ELVEN J. BERKHEISER PRIZE COMPETITION OPEN**—The Institute of Medicine of Chicago has solicited entries in the annual competition for orthopaedic surgery research. The prize, which carries a cash award of $750, recognizes pertinent work from physicians who received their M.D. a maximum of six years prior to July 1, 1978 (excluding active duty in the armed forces.) Research should be conducted primarily at a metropolitan Chicago institution. Manuscripts and a resume must be submitted to the Secretary of the Institute of Medicine of Chicago no later than November 15, 1978. For further information, contact the Institute at 332 S. Michigan Avenue, Chicago 60604.

**PHYSICIANS IN THE NEWS**—ISMS Secretary-Treasurer **Audley F. Connor, Jr., M.D.,** has been appointed acting medical director for Jackson Park Hospital, Chicago. Dr. Connor is assistant professor in preventive medicine and community health at the University of Illinois and clinical instructor of medicine at Chicago Medical School.

**Clinton L. Compere, M.D.,** Evanston, was recently named chairman of the Department of Orthopaedic Surgery at Northwestern University Medical School. . . . **George Gee Jackson, M.D.,** Hinsdale, was recently awarded the "Senior U.S. Scientist Award," an international honor for excellence in research and teaching. Dr. Jackson is the tenth American physician to win the award.

Former IDPH director **Joyce C. Lashof, M.D.,** has resigned from her post with the U.S. Department of Health Education and Welfare. Dr. Lashof had been the highest-placed female physician in the U.S.

**Ruy V. Lourenco, M.D.,** Chicago, recently received the Edmund Francis Foley Professorship of Medicine from the UI College of Medicine. Dr. Lourenco, head of the Department of Medicine at that institution, was also recently given a fellowship in the American Association for the Advancement of Science for his work in respiratory physiology.

A new medical library in the Memorial Medical Center, Springfield, has been named in honor of **Kenneth H. Schnepp, M.D.** Dr. Schnepp recently retired after 30 years on the Memorial surgical staff. . . . **Joshua A. Fierer, M.D., Peoria,** has been appointed chairman of the Department of Pathology at the University of Illinois Peoria School of Medicine. . . . **Philip H. Heller, M.D.,** Chicago, is serving as associate director for the Family Practice Residency program at Resurrection Hospital in Chicago. Dr. Heller is the former chairman of the Division of Family Practice and director of the Family Practice Residency Program for Lutheran General Hospital.

**Robert K. Anzinger, M.D.,** Chicago, has been elected president of the Illinois Division of the American Trauma Society. . . . The Chicago Thoracic Society has new officers: **Whitney W. Addington, M.D.,** Chicago, president, **G. Stephen Scholly, M.D.,** Park Ridge, secretary, and **Norman Solliday, M.D.,** Chicago and **Melvin Lopata, M.D.,** Skokie, board members-at-large.

**George A. Sisson, M.D.,** Chicago, has been elected president of the American Academy of Facial Plastic and Reconstructive Surgery. Dr. Sisson is a professor and chairman of the Department of Otolaryngology and Maxillofacial Surgery at both Northwestern University Medical Center and Chicago Wesley Memorial Hospital.

The Illinois Psychiatric Society has elected new officers, who will serve until May of 1979. They are: **Jerome S. Beigler, M.D.,** Chicago, president, **Patrick R. Staunton, M.D.,** Oak Park, president-elect, **Robert Nunn, M.D.,** Glencoe, secretary and **Brenda Solomon, M.D.,** Glencoe, treasurer.

The Chicago Pediatric Society also has elected new officers. They are: **Thomas P. Driscoll, M.D.,** president, **Rosita Pildes, M.D.,** vice president, **David H. Lee, M.D.,** secretary, **Domingo Cherony, M.D.,** treasurer and **Billie W. Adams, M.D.,** editor.

**BEG YOUR PARDON**—A story carried in the May Doctor's News entitled "Controlled Substance Update," noted that the Illinois Dangerous Drugs Commission had rescheduled Phencyclidine (PCP) and Pentazocine (Talwin) from Schedule III to Schedule II. The triplicate prescription presently is *not* required for these two drugs. In addition, Pentazocine had been listed in Schedule IV.

The May editorial, "IMJ Editorial Board Introduced," listed members of the newly-formed board. Dr. Daniel R. Cunningham, a Wilmette pediatrician, is affiliated not with Northwestern, but rather with the Loyola University/Stritch School of Medicine.

# INDEX TO VOLUME 153

## January through June, 1978

| | |
|---|---|
| **January** | **pages 1-86** |
| **February** | **87-170** |
| **March** | **171-252** |
| **April** | **253-336** |
| **May** | **337-420** |
| **June** | **421-494** |


A

A New Look **(PRESIDENT'S PAGE)** (Fox) 486

A Source of Wound Contamination Eliminated (Johnson) 71

**ABSTRACTS OF BOARD OF TRUSTEES ACTIONS,** 11, 179, 342

Actions for Civil Malpractice **(PROFESSIONAL LIABILITY)** (Folonie) 104, 276

Acutely Disturbed Psychotic Patients Treated With Parenteral Haloperidol (Firling) 117

Administrator's Perspective, The **(ATTACKING THE COST CRISIS)** (Maroney) 300

AMA Proposed Amendments to P.L. 93-641: The National Health Planning and Resources Development Act **(SPECIAL ARTICLE)** 265

A Matter of Principles: AMA Proposed New Principles of Medical Ethics **(SPECIAL ARTICLE)** 278

AMA: Attacking the Cost Crisis **(GUEST EDITORIAL)** 22

AMA: Who's Crying Waste? Why the Last of the Big Spenders! **(GUEST EDITORIAL)** 109

Amdur, Mark A., Frequent Questions About Long-Acting Injectable Fluphenazine 193

Amygdalin-Laetrile, Illinois Department of Public Health Policy Regarding, **(SPECIAL ARTICLE)** 244

An Historic Responsibility **(EDITORIAL)** (Wilkins) 433

Anatomy of Sudden Death, The (Parks) 447

Anderson, Philip C., Brown Recluse Spider Bites—Some Immunologic Aspects **(SEMINARS IN IMMUNOPATHOLOGY AND ONCOLOGY)** Richard J. Ablin, Ph.D., *Contributing Editor* 150

Attacking the Cost Crisis **(GUEST EDITORIAL)** (AMA) 22

**ATTACKING THE COST CRISIS**

Physicians Viewpoint on Cost Containment (Ingalls) 125

Is One Million Enough, Mr. Secretary? (Mungerson) 126

Cost Containment (Seeger) 127

Cost Containment Ideas (Shaw) 128

Things We Have Done—Or Should Do (Doyle) 298

The Long Range Solution to Cost Containment (Shaw) 299

The Administrator's Perspective (Maroney) 300

**AUXILIARY, PULSE OF THE ISMS** 38, 144, 230, 310, 396, 467

B

Baffes, Thomas G., *jt. author.* CME Conference: Penetrating Wounds of the Neck and Mediastinum (Paniker) 129

Beal John M., *Contributing Editor* **(SURGICAL GRAND ROUNDS)** 66, 154, 305, 462

Benign Osteoblastoma: Case Report (Kaminski, Zaitoon) 452

Bilateral Knee Effusions in Sickle Cell Crisis **(RHEUMATOLOGY ROUNDS)** L. F. Layfer, J. V. Jones, *Contributing Co-Editors* 83

Board of Trustees **(ABSTRACTS OF BOARD ACTIONS)** 11, 179, 342
Bombeck, C. T., *jt. author,* Zollinger-Ellison Syndrome: Treatment with Histamine $H_2$ Receptor Antagonists (Siepler, Donahue, Campagna) 283
Brachial Artery, Case Report: Iatrogenic Injury of the **(SURGICAL GRAND ROUNDS)** John M. Beal, *Contributing Editor* 305
Brown Recluse Spider Bites: Some Immunologic Aspects **(SEMINARS IN IMMUNOPATHOLOGY AND ONCOLOGY)** (Anderson) Richard J. Ablin, Ph.D., *Contributing Editor* 150

C

Campagna. Keith, Pharm.D., *jt. author,* Zollinger-Ellison Syndrome: Treatment with Histamine $H_2$ Receptor Antagonists (Bombeck, Siepler, Donahue) 283
Cardiac Pacing in A Community Practice, Temporary, (Coder) 27
Case Report: Benign Osteoblastoma (Kaminski, Zaitoon) 452
Case Report: Closed Mitral Commisurotomy **(SURGICAL GRAND ROUNDS)** John M. Beal, *Contributing Editor* 66
Case Report: Gastrointestinal Hemorrhage in a Three-Year-Old Child **(SURGICAL GRAND ROUNDS)** John M. Beal, *Contributing Editor* 154
Case Report: Iatrogenic Injury of the Brachial Artery **(SURGICAL GRAND ROUNDS)** John M. Beal, *Contributing Editor* 305
**CLINICS FOR CRIPPLED CHILDREN** 39, 89, 239, 255, 341, 423
Closed Mitral Commisurotomy: Case Report **(SURGICAL GRAND ROUNDS)** John M. Beal, *Contributing Editor* 66
Coder, Donald M., Temporary Cardiac Pacing in a Community Practice 27
CME Conference: Penetrating Wounds of the Neck and Mediastinum (Paniker, Baffes) 129
Complement Updated for the Clinician **(SEMINARS IN IMMUNOPATHOLOGY AND ONCOLOGY)** Richard J. Ablin, *Contributing Editor,* (Palmer) 455
Contamination Eliminated, A Source of Wound (Johnson) 71
Continuing Medical Education, ISMS Guide to, 40, 146, 197, 316, 408, 470
Continuing Medical Education Regulations, New, **(SPECIAL ARTICLE)** 50
**CONVENTION PROGRAM, 1978 ANNUAL MEETING**
Members of the 1978 House of Delegates 203
Downstate Delegates 204
Cook County Delegates 205
Officers of County Medical Societies 206
Agenda of the House of Delegates 211
Committees of the House of Delegates 213
Program Summary by Days 214
Auxiliary Convention Program 215
Resolutions 216
Student Business Session Annual Meeting Program 218
**CONVENTION HIGHLIGHTS, 1978 ANNUAL MEETING**
1978-1979 Officers and Board of Trustees 366
Highlights of the 1978 Annual Meeting 367
Summary of House of Delegates Actions 377
Actions on Resolutions 381
**CONVENTION HIGHLIGHTS,** 1977 Interim Session
Summary of House of Delegates Actions 43
Actions on Resolutions 47
Cost Challenge, The **(PRESIDENT'S PAGE)** (Fox) 415
Cost Crisis, Attacking The, **(GUEST EDITORIAL)** (AMA) 22
**COST CRISIS, ATTACKING THE**
Physicians Viewpoint on Cost Containment (Ingalls) 125
Is One Million Enough Mr. Secretary? (Mungerson) 126
Cost Containment (Seeger) 127
Cost Containment Ideas (Shaw) 128
The Long Range Solution to Cost Containment (Shaw) 299
The Administrator's Perspective (Maroney) 300
Things We Have Done—Or Should Do (Doyle) 298
Cost Containment **(ATTACKING THE COST CRISIS)** (Seeger) 127
Cost Containment Ideas **(ATTACKING THE COST CRISIS)** (Shaw) 128
Cost Containment, Physician's Viewpoint On **(PRESIDENT'S PAGE)** (Wilkins) 158
Cost Containment, Physicians Viewpoint on, **(ATTACKING THE COST CRISIS)** (Ingalls) 125
Cost Containment, The Long Range Solution to, **(ATTACKING THE COST CRISIS)** (Shaw) 299
Crippled Children, Clinics for, 39, 89, 239, 255, 341, 423

D

DeHaen, Paul, **(NEW PHARMACEUTICAL SPECIALTIES)** 25, 148, 364
Detection of Asymptomatic Bacteriuia in Juvenile Diabetes Mellitus (Nelson, Marr, Traisman) 118
Diabetes Mellitus, Detection of Asymptomatic Bacteriuria in Juvenile, (Nelson, Marr, Traisman) 118
**DOCTOR'S NEWS** 79, 159, 245, 329, 413, 487
Donahue, Philip, *jt. author,* Zollinger-Ellison Syndrome: Treatment with Histamine $H_2$ Receptor Anatagonists (Campagna, Bonbeck, Siepler) 283
Doyle, L. S., Things We Have Done or Should Do **(ATTACKING THE COST CRISIS)** 298
Drug Pharmacokinetics in Patients with Renal Failure (Franson, Sorenson) 111

E

**EDITORIALS**
An Historic Responsibility (Wilkins) 433
Legal Disaster (Hirsch) 93
IMJ Editorial Board Introduced (Roddick) 345
Edwards, Larry D., Environmental Decontamination: A Major Approach to Infection Control? 121
**EKG OF THE MONTH** (John F. Moran, M.S., M.D., David L. Fishman, M.D., Patrick J. Scanlon, M.D., Sarah A. Johnson, M.D., John R. Tobin, M.S., M.D., Rolf M. Gunnar, M.S., M.D.) 6, 92, 180, 258, 356, 432
Environmental Decontamination: A Major Approach to Infection Control? (Edwards) 121
Extensor Tendon Rupture in a Rheumatoid Hand **(RHEUMATOLOGY ROUNDS)** (L. F. Layfer and J. V. Jones, *Contributing Co-Editors*) 318

F

Firling, Randall J., Acutely Disturbed Psychotic Patients Treated with Parenteral Haloperidol 117
Fishman, David L., (See **EKG OF THE MONTH)**
Fluphenazine, Frequent Questions About Long-Acting Injectable, (Amdur) 193
Folonie, Rohert J., L.L.B., Actions for Civil Malpractice **(PROFESSIONAL LIABILITY)** 104, 276
Fox, David S., **(PRESIDENT'S PAGE)** 331, 415, 486
Franson, T. R., R.Ph., *jt. author,* Drug Pharmacokinetics in Patients with Renal Failure (Sorensen) 111
Frequent Questions About Long-Acting, Injectable Fluphenazine (Amdur) 193

G

Gastrointestinal Hemorrhage in a Three-Year-Old Child **(SURGICAL GRAND ROUNDS)** John M. Beal, *Contributing Editor* 154
Generic Substitution to be Implemented **(SPECIAL ARTICLE)** 440
**GUEST EDITORIALS**
Attacking the Cost Crisis (AMA) 22
Who's Crying Waste? Why the Last of the Big Spenders! (AMA) 109
A Long Look Ahead (Lesher) 229
Gun Shot Wound to the Neck **(SURGICAL GRAND ROUNDS)** John M. Beal, *Contributing Editor,* 462
Gunnar, Rolf M., (See **EKG OF THE MONTH)**

H

Haloperidol, Acutely Disturbed Psychotic Patients Treated with, (Firling) 117
Heinemann, Randall, M.A.P.A., *jt. author,* Impact of Community Mental Health Programs on Hospitalization for Mental Illness: An Historical Perspective (Smith, Krzyzanowski) 359
Hirsch, Lawrence L., Legal Disaster **(EDITORIALS)** 93
Histamine $H_2$ Receptor Anatgonists, Zollinger-Ellison Syndrome: Treatment with, (Siepler, Donahue, Campagna, Bombeck) 283
**HOUSE OF DELEGATES ACTIONS: 1977 INTERIM SESSION** 43
**HOUSE OF DELEGATES: 1978 ANNUAL MEETING** 377
**HOUSESTAFF NEWS** (Linda L. Hughey) 14, 138, 188, 270, 446
Hughey, Linda L., **(HOUSESTAFF NEWS)** 14, 138, 188, 270, 446

I

Iatrogenic Injury of the Brachial Artery: Case Report **(SURGICAL GRAND ROUNDS)** John M. Beal, *Contributing Editor,* 305
Illinois Department of Public Health Policy Regarding Amygdalin-Laetrile **(SPECIAL ARTICLE)** 244
Illinois Experience with MECO, The **(SPECIAL ARTICLE)** (Roxe) 288
**ILLINOIS SOCIETY, AMERICAN ASSOCIATION OF MEDICAL ASSISTANTS** 64, 143, 251, 314, 412, 468
IMJ Editorial Board Introduced **(EDITORIALS)** (Roddick) 345
Immunopathologie Aspects of Renal Disease, Some, **(SEMINARS IN IMMUNOPATHOLOGY AND ONCOLOGY)** (Potter) Richard J. Ablin, Ph.D., *Contributing Editor* 292
Impact of Community Health Programs on Hospitalization for Mental Illness: An Historical Perspective (Smith, Krzyzanowski, Heinemann) 359
Infection Control, Environmental Decontamination: A Major Approach to, (Edwards) 121
Ingalls, J. M., Physician's Viewpoint on Cost Containment **(ATTACKING THE COST CRISIS)** 125
**ISMS GUIDE TO CONTINUING MEDICAL EDUCATION** 40, 146, 197, 316, 408, 470
Is One Million Enough Mr. Secretary? **(ATTACKING THE COST CRISIS)** (Mungerson) 126

J

Johnson, Hugh A., A Source of Wound Contamination Eliminated 71
Johnson, Sarah A., (See **EKG OF THE MONTH)**
Jones, J. V., *Contributing Co-Editor* **(RHEUMATOLOGY ROUNDS)** (Layfer) 83, 318

K

Kaminski, Robert S., *jt. author,* Case Report: Benign Osteoblastoma (Zaitoon) 452
Krzyzanowski, Margaret, B. A., *jt. author,* Impact of Community Mental Health Programs on Hospitalization for Mental Illness: An Historical Perspective (Smith, Heineman) 359

L

Laetrile, Illinois Department of Public Health Policy Regarding Amygdalin, **(SPECIAL ARTICLE)** 244
Layfer, L. F., *Contributing Co-Editor* **(RHEUMATOLOGY ROUNDS)** (Jones) 83, 318
Legal Disaster **(EDITORIAL)** (Hirsch) 93
Lesher, Richard L., A Long Look Ahead **(GUEST EDITORIAL)** 229
Letters to the Editor, 443
Long Look Ahead, A **(GUEST EDITORIAL)** 229
Long Range Solution to Cost Containment, The **(ATTACKING THE COST CRISIS)** (Shaw) 299
Love Leon, *Contributing Editor* **(VIEWBOX)** 19, 99, 182, 264, 352, 430

M

Malpractice, Actions for Civil, **(PROFESSIONAL LIABILITY)** (Folonie) 104, 276
Maroney, George, The Administrator's Perspective **(ATTACKING THE COST CRISIS)** 300
Marr, Thomas J., *jt. author,* The Detection of Asymptomatic Bacteriuria in Juvenile Diabetes Mellitus (Nelson, Traisman) 118
MECO, The Illinois Experience with, **(SPECIAL ARTICLE)** (Roxe) 288
Medical Assistants, Illinois Society, American Association of, 64, 143, 251, 314, 468
Medical Ethics, AMA Proposed New Principles of, **(SPECIAL ARTICLE)** 278
**MEMBERSHIP FORUM** 416, 472

Mental Illness: An Historical Perspective, Impact of Community Mental Health Programs on Hospitalization for, (Smith, Krzyzanowski, Heinemann) 359
Moran, John F., (See **EKG OF THE MONTH)**
Mucocutaneous Lymph Node Syndrome (Reddy) (Ruth A Seeler, *Contributing Editor*) **(PEDIATRIC PERPLEXITIES)** 326
Mungerson, Gerald W., Is One Million Enough Mr. Secretary? **(ATTACKING THE COST CRISIS)** 126

N

National Health Planning and Resources Development Act: AMA Proposed Amendments to Public Law 93-641, **(SPECIAL ARTICLE)** 265
Neck and Mediastinum, CME Conference, Penetrating Wounds of the, (Paniker, Baffes) 129
Nelson, Richard P., *jt. author,* The Detection of Asymptomatic Bacteriuria in Juvenile Diabetes Mellitus (Marr, Traisman) 118
New Continuing Medical Education Regulations **(SPECIAL ARTICLE)** 50
New Pharmaceutical Specialties (DeHaen) 25, 148, 364

O

**OBITUARIES** 20, 100, 185, 261, 351, 481

P

Palmer, David G., Complement Updated for the Clinician **(SEMINARS IN IMMUNOPATHOLOGY AND ONCOLOGY)** Richard J. Ablin, *Contributing Editor* 455
Paniker, G. V., *jt. author,* CME Conference: Penetrating Wounds of the Neck and Mediastinum (Baffes) 129
Parenteral Haloperidol, Acutely Disturbed Psychotic Patients Treated with (Firling) 117
Parks, Harry W., The Anatomy of Sudden Death 447
**PEDIATRIC PERPLEXITIES** (Ruth Andrea Seeler, *Contributing Editor*) Mucocutaneous Lymph Node Syndrome (Reddy) 326
Penetrating Wounds of the Neck and Mediastinum, CME Conference, (Paniker, Baffes) 129
**PHYSICIAN RECRUITMENT PROGRAM** 59, 136, 236, 312, 402, 474
Physician's Viewpoint on Cost Containment **(ATTACKING THE COST CRISIS)** (Ingalls) 125
Physicians Viewpoint on Cost Containment **(PRESIDENT'S PAGE)** (Wilkins) 158
Potter, Elizabeth V., Some Immunopathologic Aspects of Renal Disease **(SEMINARS IN IMMUNOPATHOLOGY AND ONCOLOGY)** Richard J. Ablin, Ph.D., *Contributing Editor* 292
**PRESIDENT'S PAGE** David S. Fox
A New Look 486
Time Well Spent, 331
The Cost Challenge 415
**PRESIDENT'S PAGE** George T. Wilkins, Jr.
The Professions Image 78
Physicians Viewpoint On Cost Containment 158
Tonic or Snake Oil? 247
**PROFESSIONAL LIABILITY**
Actions for Civil Malpractice (Folonie) 104, 276
Psychotic Patients Treated with Parenteral Haloperidol, Acutely Disturbed (Firling) 117
Public Health Policy Regarding Amygdalin-Laetrile, Illinois Department of, **(SPECIAL ARTICLE)** 244
**PULSE OF THE ISMS AUXILIARY** 38, 144, 230, 310, 396, 467

R

Radiology in Malpractice Cases **(SPECIAL ARTICLE)** (Thomas) 35
Reddy, Adisesha B., Mucocutaneous Lymph Node Syndrome **(PEDIATRIC PERPLEXITIES)** Ruth Andrea Seeler, *Contributing Editor,* 326
Renal Disease, Some Immunopathologic Aspects of, **(SEMINARS IN IMMUNOPATHOLOGY AND ONCOLOGY)** (Potter) Richard J. Ablin, *Contributing Editor* 292
Renal Failure, Drug Pharmacokinetics in Patients with, (Franson, Sorenson) 111
Resolutions, Actions on House of Delegates 47, 381
**RHEUMATOLOGY ROUNDS** (L. F. Layfer, and J. V. Jones, *Contributing Co-Editors*)
Bilateral Knee Effusions in Sickle Cell Crisis 83
Extensor Tendon Rupture in a Rheumatoid Hand 318
Roddick, J. William, **(EDITORIAL)** IMJ Editorial Board Introduced 345
Roxe, David M., **(SPECIAL ARTICLE)** The Illinois Experience with MECO 288

S

Scanlon, Patrick J., See **EKG OF THE MONTH**
Seeger, Robert W., Cost Containment **(ATTACKING THE COST CRISIS)** 127
Seeler, Ruth Andrea, *Contributing Editor* **(PEDIATRIC PERPLEXITIES)** 326
**SEMINARS IN IMMUNOPATHOLOGY AND ONCOLOGY** (Richard J. Ablin, Ph.D., *Contributing Editor*
Brown Recluse Spider Bites—Some Immunologic Aspects (Anderson) 150
Complement Updated for the Clinician (Palmer) 455
Some Immunopathologic Aspects of Renal Disease (Potter) 292
Shaw, Richard C., Cost Containment Ideas **(ATTACKING THE COST CRISIS)** 128
Shaw, Richard C., The Long Range Solution to Cost Containment **(ATTACKING THE COST CRISIS)** 299
Sickle Cell Crisis, Bilateral Knee Effusions in, **(RHEUMATOLOGY ROUNDS)** L. F. Layfer and J. V. Jones, *Contributing Co-Editors* 83
Siepler, John K., Pharm.D., *jt. author,* Zollinger-Ellison Syndrome: Treatment With Histamine $H_2$ Receptor Antagonists (Donahue, Campagna, Bombeck) 283
Smith, William G., *jt. author,* Impact of Community Mental Health Programs on Hospitalization for Mental Illness: An Historical Perspective (Krzyzanowski, Heinemann) 359
Sorensen, E. T., *jt. author,* Drug Pharmacokinetics in Patients with Renal Failure (Franson) 111
Source of Wound Contamination Eliminated, A, (Johnson) 71
Spider Bites—Some Immunologic Aspects, Brown Recluse, **(SEMINARS IN IMMUNOPATHOLOGY AND ONCOLOGY)** (Anderson) Richard J. Ablin, *Contributing Editor* 150
**SUMMARY OF ACTIONS, ISMS HOUSE OF DELEGATES**
1977 Interim Session 43
1978 Annual Meeting 377

**SURGICAL GRAND ROUNDS,** John M. Beal, *Contributing Editor*
Case Report: Closed Mitral Commisurotomy 66
Case Report: Gastrointestinal Hemorrhage in a Three-Year-Old Child 154
Case Report: Iatrogenic Injury of the Brachial Artery 305
Gun Shot Wound to the Neck 462

T

Temporary Cardiac Pacing in a Community Practice (Coder) 27
The Profession's Image **(PRESIDENT'S PAGE)** (Wilkins) 78
Things We Have Done—Or Should Do **(ATTACKING THE COST CRISIS)** (Doyle) 298
Thomas, William A., Radiology in Malpractice Cases **(SPECIAL ARTICLE)** 35
Time Well Spent **(PRESIDENT'S PAGE)** (Fox) 331
Tobin, John R., Jr., (See **EKG OF THE MONTH)**
Tonic or Snake Oil? **(PRESIDENT'S PAGE)** (Wilkins) 247
Traisman, Howard S., *jt. author,* The Detection of Asymptomatic Bacteriuria in Juvenile Diabetes Mellitus (Nelson, Marr) 118

V

**VIEWBOX** (Leon Love, *Contributing Editor*) 19, 99, 182, 264, 352, 430

W

Who's Crying Waste? Why the Last of the Big Spenders! **(GUEST EDITORIAL)** (AMA) 109
Wilkins, George T., **(PRESIDENT'S PAGE)** 78, 158, 247
An Historic Responsibility **(EDITORIAL)** 433
Wounds of the Neck and Mediastinum, CME Conference on Penetrating, (Paniker, Baffes) 129

Z

Zaitoon, Mohammad Munir, *jt. author,* Case Report: Benign Osteoblastoma (Kaminski) 452
Zollinger-Ellison Syndrome: Treatment with Histamine $H_2$ Receptor Antagonists (Siepler, Donahue, Campagna, Bombeck) 283

**Professionals are talking about . . .**




**CLOVER LEAF TOWERS OFFICE PLAZA**

**Ideally located & suited for professionals.**
10 MINUTES TO I-90 • 30 MINUTES TO CHICAGO
**NEW 3 STORY • ALL ELECTRIC • WITH ELEVATOR**

- Heating & Air-Conditioning Included
- Carpeting — Your Color Choice
- More Than Ample Parking
- Fine Restaurant Located in Building
- Ideal For Medical, Dental Offices
- Entire Floor 10,000 Sq. Ft. — Will Divide
- Tinted Glass — FM Music
- Public & Private Restrooms
- 2 Year Lease — No Increase
- Solid Oak Doors — Vinyl Base
- Individually Controlled Thermostat
- Immediate Occupancy — Brokers Invited

**CLOVER-LEAF REALTY**
**201 E. Army Trail (1½ Miles West of Rte. 53)**
**Bloomingdale, Ill.**
**PHONE 893-1000**

IMJ
Illinois Medical Journal

# YOUR ADVERTISERS

*Our advertisers serve the Medical Profession and support your Journal. All advertisers are approved by your Journal Committee. It will help you and your society to mention your Journal when writing them.*

## Space Representatives

United Media Associates, Inc., 16 Bruce Park Avenue, Greenwich, Conn. 06830

## Pharmaceuticals

425-426 Abbott Laboratories
*Tranxene*

434-436 Boehringer Ingelheim
*Catapres*

480-481 Bristol Laboratories
Div. of Bristol-Myers Co.
*Tegopen*

Cover 2 Burroughs Wellcome Co.
*Neosporin*

437-438 Geigy Pharmaceuticals
Div. of Ciba-Geigy Corp.
*Tofranil—P.M.*

444 Eli Lilly and Company
*Darvon*

441-442 Mead Johnson Laboratories
*Colace*
*Vasodilan*

423-424 Roche Laboratories
Div. of Hoffman-LaRoche
*Librax*

Covers 3&4 Roche Laboratories
Div. of Hoffman-LaRoche
*Librium*

485 Smith Kline and French Labs.
Div. of SmithKline Corp.
*Dyazide*

445 Upjohn Pharmaceuticals
*Tolinase*

429 Warren Teed Laboratories
*Kaon Elixir & Tabs*

431 Warren Teed Laboratories
*Modane*

## Insurance

466 Medical Protective Co.
*Professional Liability Ins.*

469 Parker Aleshire and Co.
*Group Insurance*

## Services and Continuing Education

479 American International Hospital
*Practice Opportunities*

427-428 Blue Cross and Blue Shield
Report

454 Cameron Memorial Hospital
*Practice Opportunities*

476 Classified Advertising

493 Clover Leaf Towers
*Office Space*

443 Cook County Graduate School
*Continuing Medical Education*

478 INTRAV
*Eastern Mediterranean*
*Air/Sea Cruise*

470 ISMS Guide in Continuing
Medical Education

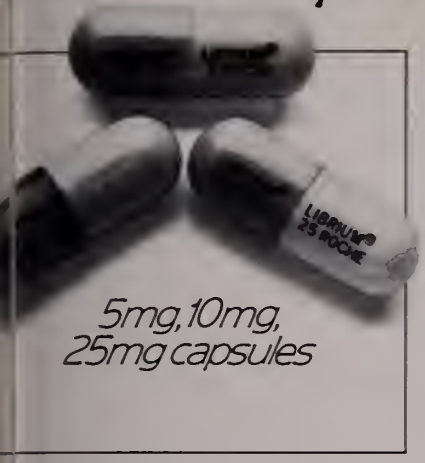
484 Mann Levine & Weiss
*Pension Consultants*

466 O'Hare International Autos
*Leasing Service*

482-483 Pharmaceutical Manufacturers
Association
*Patient Package Inserts*

477 Ravenswood Hospital Medical
Center
*Continuing Medical Education*

# Librium®
## chlordiazepoxide HCl/Roche




5mg, 10mg, 25mg capsules

- ☐ Proven antianxiety performance
- ☐ An unsurpassed safety record
- ☐ Predictable patient response
- ☐ Minimal effect on mental acuity at recommended doses
- ☐ Minimal interference with many primary medications, such as antacids, anticholinergics, diuretics, cardiac glycosides and antihypertensive agents

**ore prescribing, please consult complete product information, a summary of which follows:**

**Indications:** Relief of anxiety and tension occurring alone ccompanying various disease states. Efficacy beyond months not established by systematic clinical studies. eriodic reassessment of therapy recommended.

**Contraindications:** Patients with known hypersensitivity e drug.

**Warnings:** Warn patients that mental and/or physical abil- required for tasks such as driving or operating ma- hery may be impaired, as may be mental alertness in chil- n, and that concomitant use with alcohol or CNS depres- s may have an additive effect. Though physical and psy- hological dependence have rarely been reported on recom- ded doses, use caution in administering to addiction- e individuals or those who might increase dosage; with- wal symptoms (including convulsions), following discon- nuation of the drug and similar to those seen with barbi- es, have been reported.

**sage in Pregnancy: Use of minor tranquilizers during rst trimester should almost always be avoided be- ause of increased risk of congenital malformations as uggested in several studies. Consider possibility of regnancy when instituting therapy; advise patients discuss therapy if they intend to or do become regnant.**

**Precautions:** In the elderly and debilitated, and in chil- over six, limit to smallest effective dosage (initially 10 r less per day) to preclude ataxia or oversedation, in- sing gradually as needed and tolerated. Not recom- ded in children under six. Though generally not recom- ded, if combination therapy with other psycho- cs seems indicated, carefully consider individual phar- logic effects, particularly in use of potentiating drugs as MAO inhibitors and phenothiazines. Observe usual utions in presence of impaired renal or hepatic func- Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

**Adverse Reactions:** Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

**Usual Daily Dosage:** Individualize for maximum beneficial effects. Oral—Adults: Mild and moderate anxiety and tension, 5 or 10 mg t.i.d. or q.i.d.; severe states, 20 or 25 mg t.i.d. or q.i.d. Geriatric patients: 5 mg b.i.d. to q.i.d. (See Precautions.)

**Supplied:** Librium® (chlordiazepoxide HCl) Capsules, 5 mg, 10 mg and 25 mg—bottles of 100 and 500; Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10; Prescription Paks of 50, available singly and in trays of 10. Libritabs® (chlordiazepoxide) Tablets, 5 mg, 10 mg and 25 mg—bottles of 100 and 500. With respect to clinical activity, capsules and tablets are indistinguishable.

## ynonymous with relief of anxiety

ROCHE
Roche Products Inc.
Manati, Puerto Rico 00701

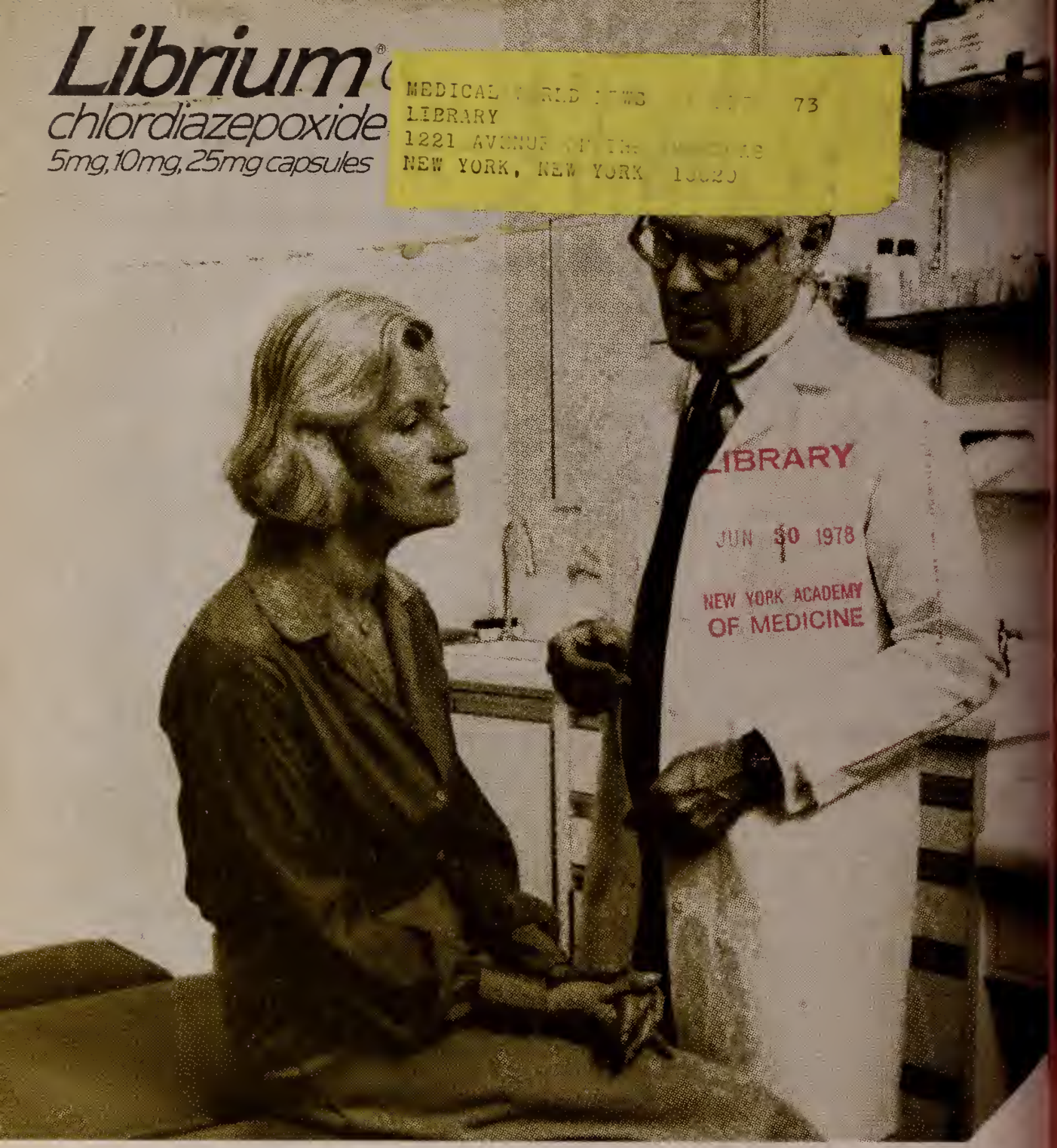
Please see following page.

# Librium®

chlordiazepoxide

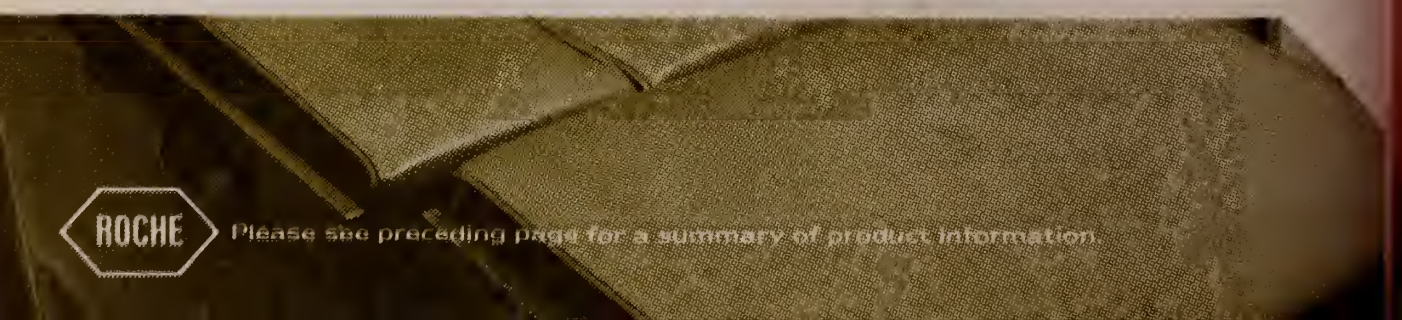
5mg, 10mg, 25mg capsules

MEDICAL WORLD NEWS 73
LIBRARY
1221 AVENUE OF THE AMERICAS
NEW YORK, NEW YORK 10020



LIBRARY
JUN 30 1978
NEW YORK ACADEMY
OF MEDICINE

## synonymous with relief of anxiet



ROCHE

Please see preceding page for a summary of product information.

# *Illinois Medical Journal*

BALCONY
portrait p 53

OFFICIAL JOURNAL OF THE
ILLINOIS STATE MEDICAL SOCIETY

VOLUME 154, NO. 1, JULY, 1978

BALCONY

**Rape: a community hospital study . . . 25**
**Bedside barium enema: a new approach . . . 29**
**Pediatric perplexities: organophosphate poisoning . . . 32**
**Case report: coronary artery surgery . . . 36**

**Table of contents . . . 1**
**President's page . . . 53**

2 EAST 103RD STREET
NEW YORK, NEW YORK 10029



# EMPIRIN® COMPOUND
# with CODEINE

Each tablet contains: aspirin 227 mg, phenacetin 162 mg, and caffeine 32 mg, plus codeine phosphate in one of the following strengths: #4—60 mg (gr. 1); #3—30 mg (gr. ½); #2—15 mg (gr. ¼); and #1—7.5 mg (gr. ⅛). (Warning—may be habit-forming)

C III

Burroughs Wellcome Co.
Research Triangle Park
North Carolina 27709

IMJ

Illinois Medical Journal

JULY, 1978 Vol. 154, No. 1 CONTENTS

4 Abstracts of Board of Trustees Actions

*Clinical Articles*

25 Rape: A Community Hospital Study
*By Pedro A. Poma, M.D., and Robert C. Stepto, M.D.*

29 Bedside Barium Enema: A New Approach
*By Samuel C. Balderman, M.D., Krishnan Sriram, M.D., and Arthur G. Michel, M.D.*

*Rheumatology Rounds*

22 Painful Anterior Shoulder Mass With Calcification
*L. F. Layfer, M.D., and J. V. Jones, M.D., Contributing Co-Editors*

*Pediatric Perplexities*

32 Organophosphate Poisoning
*Ruth Andrea Seeler, M.D., Contributing Editor*
*By Iqbal A. Memon, M.D.*

*Surgical Grand Rounds*

36 Case Report: Coronary Artery Surgery
*John M. Beal, M.D., Contributing Editor*

*President's Page*

53 Mandatory CME
*David S. Fox, M.D.*

*(Contents continued on overleaf)*

## *Features*


6 EKG of the Month
11 Clinics for Crippled Children
12 Pulse of the ISMS Auxiliary
15 Illinois Society, American Association of Medical Assistants
16 Obituaries
42 ISMS Guide to Continuing Medical Education
44 Classified Advertising
51 Doctor's News
54 Physician Recruitment


## *Staff*


**Managing Editor** ..... **Richard A. Ott**
**Assistant Editor** ..... **Mariann M. Stephens**
**Executive Administrator** ..... **Roger N. White**

*(Cover by Jane and C. R. Bushwaller)*

### PUBLICATIONS COMMITTEE

Herschel Browns, M.D., Chicago, *Chairman*
Kenneth A. Hurst, M.D., Naperville
Robert P. Johnson, M.D., Springfield
Alfred J. Kiessel, M.D., Decatur
Harold J. Lasky, M.D., Chicago

### Editorial Board

J. William Roddick, Jr., M.D., *Chairman*
Eli L. Borkon, M.D., Carbondale
Daniel R. Cunningham, M.D., Wilmette
Raymond A. Dieter, Jr., M.D., Glen Ellyn
James G. Ekeberg, M.D., Palatine
Ediz Z. Ezdinli, M.D., Kenilworth
Carl Neuhoff, M.D., Peoria
Constantine S. Soter, M.D., Arlington Heights
Donald D. VanFossan, M.D., Springfield

Contributor in Surgery: John M. Beal, M.D., Chicago
Contributor in Maternal Death Studies: Robert R. Hartman, M.D., Jacksonville
Contributor in Pediatric Perplexities: Ruth Andrea Seeler, M.D., Chicago
Contributor in Radiology: Leon Love, M.D., Maywood
Contributor in Cardiology: John R. Tobin, M.D., Maywood
Contributor in Immunopathology: Richard J. Ablin, Ph.D., Chicago
Contributor in Rheumatology: L. F. Layfer, M.D., Chicago

### ILLINOIS STATE MEDICAL SOCIETY

#### OFFICERS

David S. Fox, M.D., President
826 E. 61st St., Chicago 60637
P. John Seward, M.D., President-Elect
310 N. Wyman St., Rockford 61101
Herschel Browns, M.D., 1st Vice-President
4600 N. Ravenswood, Chicago 60640
G. W. Giebelhausen, M.D., 2nd Vice-President
1101 Main St., Peoria 61606
Audley F. Connor, Jr., M.D., Secretary-Treasurer
7531 S. Stony Island Ave., Chicago 60649

#### HOUSE OF DELEGATES

Cyril C. Wiggishoff, M.D., Speaker
25 E. Washington, Chicago 60602
Robert P. Johnson, M.D., Vice-Speaker
108 Maple Grove, Springfield 62707

#### TRUSTEES

1st District: 1980, John J. Ring, M.D.
511 Hawley, Mundelein 60060
2nd District: 1980, Allan L. Goslin, M.D.
712 N. Bloomington, Streator 61364
3rd District: 1979, Alfred Clementi, M.D.
675 W. Central Rd., Arlington Heights 60005
3rd District: 1980, Raymond J. Des Rosiers, M.D.
1044 N. Francisco, Chicago 60622
3rd District: 1979, Robert T. Fox, M.D.
2136 Robincrest, Glenview 60025
3rd District, 1979, Jere Freidheim, M.D.
3050 S. Wallace, Chicago 60616
3rd District: 1981, Morris T. Friedell, M.D.
7531 S. Stony Island Ave., Chicago 60649
3rd District: 1981, Henrietta Herbolsheimer, M.D.
5528 S. Hyde Park Blvd., Apt. 1202, Chicago 60637
3rd District: 1981, Lawrence L. Hirsch, M.D.
2434 Grace St., Chicago 60618
3rd District: 1980, Harold J. Lasky, M.D.
55 E. Washington, Chicago 60602
3rd District: 1980, Richard N. Rovner, M.D.
645 N. Michigan, Suite 920, Chicago 60611
3rd District: 1980, Joseph C. Sherrick, M.D.
303 E. Superior, Chicago 60611
4th District: 1979, Fred Z. White, M.D.
723 N. Second St., Chillicothe 61523
5th District: 1979, P. F. Mahon, M.D.
800 E. Carpenter, Springfield 62702
6th District: 1981, Robert R. Hartman, M.D.
1515 A. W. Walnut, Jacksonville 62650
7th District: 1979, Alfred J. Kiessel, M.D.
1 Powers Lane Pl., Decatur 62522
8th District: 1979, James Laidlaw, M.D.
104 W. Clark, Champaign 61820
9th District: 1981, Warren D. Tuttle, M.D.
203 N. Vine St., Harrisburg 62946
10th District: 1981, Julian W. Buser, M.D.
6600 W. Main St., Belleville 62223
11th District: 1980, Kenneth A. Hurst, M.D.
52 Bunting Lane, Naperville 60540
12th District: 1980, Joseph Perez, M.D.
5670 E. State St., Rockford 61108
Trustee-At-Large: George T. Wilkins, M.D.
3165 Myrtle, Granite City 62040
Chairman of the Board: Robert R. Hartman, M.D.
1515 A. W. Walnut, Jacksonville 62650



Microfilm copies of current as well as some back issues of the *Illinois Medical Journal* may be purchased from Xerox University Microfilm, 300 North Zeeb Road, Ann Arbor, Mich. 48106.

Contents of *IMJ* are listed in the *Current Contents/Clinical Practice.*

Published by the Illinois State Medical Society, 55 E. Monroe St., Chicago, Ill. 60603 (312-782-1654)



Copyright, 1978. The Illinois State Medical Society. All material subject to this copyright may be photocopied for the noncommercial purpose of scientific or educational advancement.



Subscription $8.00 per year, in advance, postage prepaid, for the United States, Cuba, Puerto Rico, Philippine Islands and Mexico. $10.00 per year for all foreign countries included in the Universal Postal Union. Canada $8.50. U.S. Single current copies available at $1.00 ($1.10 by mail), back issues $1.50.

Second class postage paid at Chicago, Ill. When moving please notify Journal office of new address including old mailing label with notification, if possible. POSTMASTER: Send notice on form No. 3579 to Illinois State Medical Society, 55 E. Monroe St., Chicago, Ill. 60603.

Pharmaceutical advertising must be approved by the ISMS Publications Committee. Other advertising accepted after review by Publications Committee or Board of Trustees. All copy or plates must reach the Journal office by the fifteenth of the month preceding publication. Rates furnished upon request.

Original articles will be considered for publication with the understanding that they are contributed only to the *Illinois Medical Journal.* The ISMS denies responsibility for opinions and statements expressed by authors or in excerpts, other than editorial or allied views or tatements which reflect the authoritative action of the ISMS or of reports on official actions, policies or positions. Views expressed by authors do not necessarily represent those of the Society; any connection with official policies is coincidental.

The *Illinois Medical Journal* is published by the Illinois State Medical Society as an educational and professional informational magazine and distributed as a benefit of membership in the Illinois State Medical Society. Its intent is to keep members current in medical knowledge and is a part of a continuing medical education program. Socioeconomic matters, affecting as they do a changing pattern in the proper delivery of medical care, are considered an inherent element in medical education.

# PERFORMANCE. PROVEN EFFECTIVENESS WITHIN A WIDE SAFETY MARGIN.




While Roche Laboratories already knows more about the performance of Librium than anyone else, we keep on learning every day.

For example, the highly favorable benefits-to-risk ratio of Librium is a well-documented matter of record.

And, of course, the specific calming action of Librium has been demonstrated in millions of patients around the world. In a large number of these patients, Librium was used concomitantly with other primary medications.

Proven performance within a wide safety margin. Basically, that's what Librium is all about.

# LIBRIUM® Ⓒ℞

## chlordiazepoxide HCl/Roche

## THE ANXIETY-SPECIFIC

**Before prescribing, please consult complete product information, a summary of which follows:**

**Indications:** Relief of anxiety and tension occurring alone or accompanying various disease states. Efficacy beyond four months not established by systematic clinical studies. Periodic reassessment of therapy recommended.

**Contraindications:** Patients with known hypersensitivity to the drug.

**Warnings:** Warn patients that mental and/or physical abilities required for tasks such as driving or operating machinery may be impaired, as may be mental alertness in children, and that concomitant use with alcohol or CNS depressants may have an additive effect. Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported.

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

**Precautions:** In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

**Adverse Reactions:** Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

**Supplied:** Librium® Capsules containing 5 mg, 10 mg or 25 mg chlordiazepoxide HCl. Libritabs® Tablets containing 5 mg, 10 mg or 25 mg chlordiazepoxide.

ROCHE

Roche Products Inc.
Manati, Puerto Rico 00701

## *Features*


6 EKG of the Month
11 Clinics for Crippled Children
12 Pulse of the ISMS Auxiliary
15 Illinois Society, American Association of Medical Assistants
16 Obituaries
42 ISMS Guide to Continuing Medical Education
44 Classified Advertising
51 Doctor's News
54 Physician Recruitment


## *Staff*


**Managing Editor** ..... **Richard A. Ott**
**Assistant Editor** ..... **Mariann M. Stephens**
**Executive Administrator** ..... **Roger N. White**

*(Cover by Jane and C. R. Bushwaller)*

### PUBLICATIONS COMMITTEE

Herschel Browns, M.D., Chicago, *Chairman*
Kenneth A. Hurst, M.D., Naperville
Robert P. Johnson, M.D., Springfield
Alfred J. Kiessel, M.D., Decatur
Harold J. Lasky, M.D., Chicago

### Editorial Board

J. William Roddick, Jr., M.D., *Chairman*
Eli L. Borkon, M.D., Carbondale
Daniel R. Cunningham, M.D., Wilmette
Raymond A. Dieter, Jr., M.D., Glen Ellyn
James G. Ekeberg, M.D., Palatine
Ediz Z. Ezdinli, M.D., Kenilworth
Carl Neuhoff, M.D., Peoria
Constantine S. Soter, M.D., Arlington Heights
Donald D. VanFossan, M.D., Springfield

Contributor in Surgery: John M. Beal, M.D., Chicago
Contributor in Maternal Death Studies: Robert R. Hartman, M.D., Jacksonville
Contributor in Pediatric Perplexities: Ruth Andrea Seeler, M.D., Chicago
Contributor in Radiology: Leon Love, M.D., Maywood
Contributor in Cardiology: John R. Tobin, M.D., Maywood
Contributor in Immunopathology: Richard J. Ahlin, Ph.D., Chicago
Contributor in Rheumatology: L. F. Layfer, M.D., Chicago

### ILLINOIS STATE MEDICAL SOCIETY

#### OFFICERS

David S. Fox, M.D., President
826 E. 61st St., Cbicago 60637
P. Jobn Seward, M.D., President-Elect
310 N. Wyman St., Rockford 61101
Herscbel Browns, M.D., 1st Vice-President
4600 N. Ravenswood, Chicago 60640
G. W. Giebelhausen, M.D., 2nd Vice-President
1101 Main St., Peoria 61606
Audley F. Connor, Jr., M.D., Secretary-Treasurer
7531 S. Stony Island Ave., Chicago 60649

#### HOUSE OF DELEGATES

Cyril C. Wiggishoff, M.D., Speaker
25 E. Washington, Chicago 60602
Robert P. Johnson, M.D., Vice-Speaker
108 Maple Grove, Springfield 62707

#### TRUSTEES

1st District: 1980, John J. Ring, M.D.
511 Hawley, Mundelein 60060
2nd District: 1980, Allan L. Goslin, M.D.
712 N. Bloomington, Streator 61364
3rd District: 1979, Alfred Clementi, M.D.
675 W. Central Rd., Arlington Heights 60005
3rd District: 1980, Raymond J. Des Rosiers, M.D.
1044 N. Francisco, Chicago 60622
3rd District: 1979, Robert T. Fox, M.D.
2136 Robincrest, Glenview 60025
3rd District, 1979, Jere Freidheim, M.D.
3050 S. Wallace, Chicago 60616
3rd District: 1981, Morris T. Friedell, M.D.
7531 S. Stony Island Ave., Chicago 60649
3rd District: 1981, Henrietta Herbolsheimer, M.D.
5528 S. Hyde Park Blvd., Apt. 1202, Chicago 60637
3rd District: 1981, Lawrence L. Hirscb, M.D.
2434 Grace St., Chicago 60618
3rd District: 1980, Harold J. Lasky, M.D.
55 E. Washington, Chicago 60602
3rd District: 1980, Richard N. Rovner, M.D.
645 N. Michigan, Suite 920, Chicago 60611
3rd District: 1980, Joseph C. Sherrick, M.D.
303 E. Superior, Chicago 60611
4th District: 1979, Fred Z. White, M.D.
723 N. Second St., Chillicothe 61523
5tb District: 1979, P. F. Mahon, M.D.
800 E. Carpenter, Springfield 62702
6th District: 1981, Robert R. Hartman, M.D.
1515 A. W. Walnut, Jacksonville 62650
7th District: 1979, Alfred J. Kiessel, M.D.
1 Powers Lane Pl., Decatur 62522
8th District: 1979, James Laidlaw, M.D.
104 W. Clark, Champaign 61820
9th District: 1981, Warren D. Tuttle, M.D.
203 N. Vine St., Harrisburg 62946
10th District: 1981, Julian W. Buser, M.D.
6600 W. Main St., Belleville 62223
11th District: 1980, Kenneth A. Hurst, M.D.
52 Bunting Lane, Naperville 60540
12th District: 1980, Joseph Perez, M.D.
5670 E. State St., Rockford 61108
Trustee-At-Large: George T. Wilkins, M.D.
3165 Myrtle, Granite City 62040
Chairman of the Board: Robert R. Hartman, M.D.
1515 A. W. Walnut, Jacksonville 62650



Microfilm copies of current as well as some back issues of the *Illinois Medical Journal* may he purchased from Xerox University Microfilm, 300 North Zeeb Road, Ann Arbor, Micb. 48106.

Contents of *IMJ* are listed in the *Current Contents/Clinical Practice.*

Published by the Illinois State Medical Society, 55 E. Monroe St., Chicago, Ill. 60603 (312-782-1654)



Copyright, 1978. The Illinois State Medical Society. All material subject to this copyrigbt may be pbotocopied for the noncommercial purpose of scientific or educational advancement.



Subscription $8.00 per year, in advance, postage prepaid, for the United States, Cuba, Puerto Rico, Philippine Islands and Mexico. $10.00 per year for all foreign countries included in the Universal Postal Union. Canada $8.50. U.S. Single current copies available at $1.00 ($1.10 by mail), back issues $1.50.

Second class postage paid at Chicago, Ill. When moving please notify Journal office of new address including old mailing label with notification, if possible. POSTMASTER: Send notice on form No. 3579 to Illinois State Medical Society, 55 E. Monroe St., Chicago, Ill. 60603.

Pharmaceutical advertising must he approved by the ISMS Publications Committee. Other advertising accepted after review by Publications Committee or Board of Trustees. All copy or plates must reacb the Journal office by the fifteenth of the month preceding publication. Rates furnished upon request.

Original articles will be considered for publication with the understanding that they are contributed only to the *Illinois Medical Journal.* The ISMS denies responsibility for opinions and statements expressed by authors or in excerpts, other than editorial or allied views or tatements wbich reflect the autboritative action of the ISMS or of reports on official actions, policies or positions. Views expressed by authors do not necessarily represent those of the Society; any connection with official policies is coincidental.

The *Illinois Medical Journal* is published by the Illinois State Medical Society as an educational and professional informational magazine and distributed as a benefit of membership in the Illinois State Medical Society. Its intent is to keep members current in medical knowledge and is a part of a continuing medical education program. Socioeconomic matters, affecting as they do a changing pattern in the proper delivery of medical care, are considered an inherent element in medical education.

# PERFORMANCE. PROVEN EFFECTIVENESS WITHIN A WIDE SAFETY MARGIN.




While Roche Laboratories already knows more about the performance of Librium than anyone else, we keep on learning every day.

For example, the highly favorable benefits-to-risk ratio of Librium is a well-documented matter of record.

And, of course, the specific calming action of Librium has been demonstrated in millions of patients around the world. In a large number of these patients, Librium was used concomitantly with other primary medications.

Proven performance within a wide safety margin. Basically, that's what Librium is all about.

# LIBRIUM® Ⓒ℞

## chlordiazepoxide HCl/Roche

## THE ANXIETY-SPECIFIC

**Before prescribing, please consult complete product information, a summary of which follows:**

**Indications:** Relief of anxiety and tension occurring alone or accompanying various disease states. Efficacy beyond four months not established by systematic clinical studies. Periodic reassessment of therapy recommended.

**Contraindications:** Patients with known hypersensitivity to the drug.

**Warnings:** Warn patients that mental and/or physical abilities required for tasks such as driving or operating machinery may be impaired, as may be mental alertness in children, and that concomitant use with alcohol or CNS depressants may have an additive effect. Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported.

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

**Precautions:** In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

**Adverse Reactions:** Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

**Supplied:** Librium® Capsules containing 5 mg, 10 mg or 25 mg chlordiazepoxide HCl. Libritabs® Tablets containing 5 mg, 10 mg or 25 mg chlordiazepoxide.

ROCHE

Roche Products Inc.
Manati, Puerto Rico 00701

# *Abstracts of Board Actions*

**June 3, 1978** **Chicago**

*These abstracts are published so that members of the Illinois State Medical Society may keep advised of the actions of the Board of Trustees. It covers only major actions and is not intended as a detailed report. Full minutes of the meetings are available upon any member's request at the headquarters office of ISMS.*

## Medicare Peer Review

ISMS has contracted with Electronic Data Systems (EDS) to provide peer review and professional relations services if HEW awards EDS a contract to administer Medicare Part B in Illinois. Under HEW's plan, one carrier will be selected to administer the program throughout the state. The carrier selected will begin operations April 1, 1979, in Cook County and July 1, 1979, in the remainder of the state. The peer review reimbursement rate would be $38, with county societies receiving $35 per review and ISMS retaining $3 to cover administrative costs. This is similar to the ISMS contract with Wisconsin Physicians' Service to perform peer review, facilities review and professional relations on behalf of the CHAMPUS program in Illinois.

## Medicaid

ISMS will assist the Illinois Department of Public Aid in securing the services of six physicians to review the practices of some 49 physicians suspected of prescription abuse of drugs such as Talwin and PBZ. However, ISMS will urge the reviewing physicians—who will be deputized as IDPA agents—to withdraw from the reviews if: (1) IDPA demands fiscal records; or (2) The physician being investigated refuses to produce medical records because he does not have the patient's consent. IDPA will be responsible for securing patient authorization in such cases. Findings of the reviews will be presented to the State Medical Advisory Committee.

The Society will present objections to a proposed IDPA rule which would limit reimbursement of physicians earning $25,000 or more per quarter from Medicaid to 80% of the statewide pricing screens. The level of statewide pricing screens is dependent upon the action which the General Assembly takes regarding the governor's proposed $20 million increase in physician reimbursement.

ISMS will provide legal assistance if court action results from an upcoming IDPA audit of a Chicago physician's Medicaid billings. ISMS assistance will be limited to an effort to protect the physician-patient relationship and confidentiality of medical records. Because the court decision could impact on all Illinois physicians, ISMS involvement falls within guidelines governing legal assistance adopted by the Board last August.

## Statewide PSRO Council

The Executive Committee was authorized to designate two ISMS representatives to the Statewide PSRO Council. Prior to submitting the nominations the Society will consult with the governor to discuss his appointments to the Council. HEW has requested the broadest possible physician representation (specialties and practice settings). Membership on the Council will consist of 2 physicians designated by ISMS; 2 physicians designated by Illinois Hospital Association; 1 physician representative from each PSRO in Illinois and 4 public representatives, at least two of whom will be appointed by the governor. The PSRO Council will coordinate PSRO activities, disseminate relevant data concerning the program, and assist in evaluating PSRO performance and assuring compliance.

*(Continued on page 47)*

me is the test of all things.



BRIEF SUMMARY

**Indications**: Oral potassium therapy for the prevention and treatment of hypokalemia which may occur secondary to diuretic or corticosteroid administration. May be used in the treatment of cardiac arrhythmias due to digitalis intoxication.

**Contraindications**: Severe renal impairment with oliguria or azotemia, untreated Addison's disease, adynamia episodica hereditaria, acute dehydration, heat cramps and hyperkalemia from any cause.

**Precautions:** Potassium intoxication by oral administration rarely occurs in patients with normal kidney function, however, potassium supplements must be administered with caution, since the amount of the deficiency or daily dosage is not accurately known. Frequent checks of the clinical status of the patient, and periodic ECG and/or serum potassium levels should be made. High serum concentrations of potassium ion may cause death through cardiac depression, arrhythmias or arrest. This drug should be used with caution in the presence of cardiac disease.

In hypokalemic states, especially in patients on a low-salt diet, hypochloremic alkalosis is a possibility that may require chloride as well as potassium supplementation.

**Adverse Reactions:** Nausea, vomiting, diarrhea, and abdominal discomfort have been reported. The most severe adverse effect is hyperkalemia.

**Overdosage:** Potassium intoxication may result from overdosage of potassium or from therapeutic dosage in conditions stated under "Contraindications". Hyperkalemia, when detected, must be treated immediately because lethal levels can be reached in a few hours.

# Kaon® Elixir

(potassium gluconate)

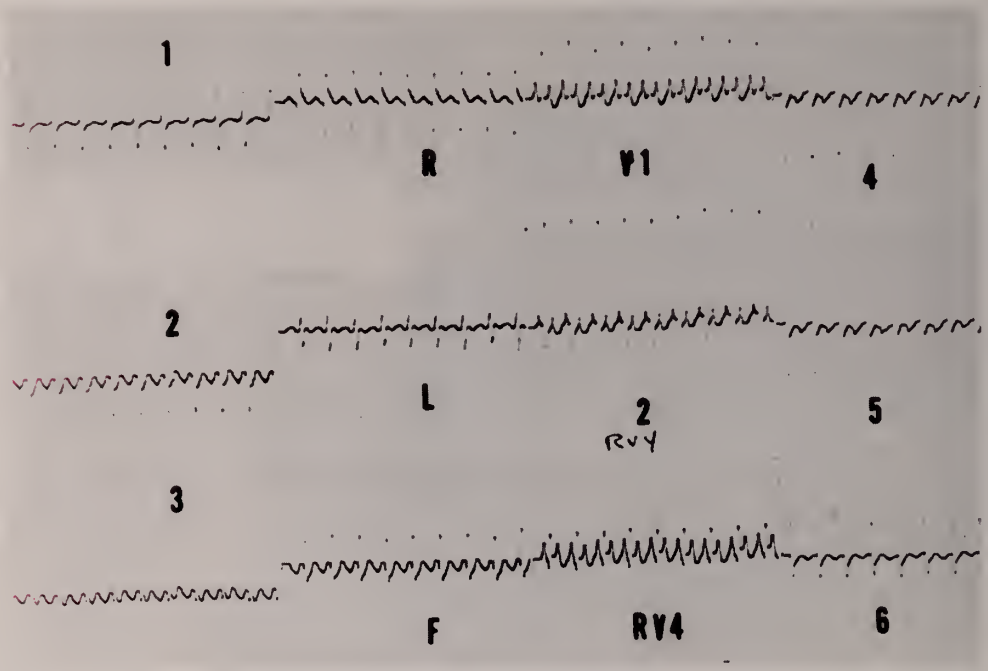
20 mEq per 15 ml

**WARREN-TEED**
LABORATORIES, INC.
DIVISION OF **AORIA LABORATORIES INC.**
COLUMBUS, OHIO 43215

# ekg of the month

John F. Moran, M.S., M.D., David L. Fishman, M.D.,
Patrick J. Scanlon, M.D., Sarah A. Johnson, M.D.,
John R. Tobin, M.S., M.D., and Rolf M. Gunnar, M.S., M.D.
Section of Cardiology, Department of Medicine,
Loyola University Stritch School of Medicine

*This patient is a five-week-old infant who presents with symptoms of congestive heart failure. He was the product of a normal labor and delivery although a tachycardia of 200 beats per minute was once recorded. Now his mother noted breathlessness and difficulty in feeding. Physical examination showed hepatomegaly, a tachycardia of 215 beats per minute, and a grade 3/6 systolic cardiac murmur at the base of the heart. This ECG was taken.*




## Questions:

**1. The ECG shows:**

A. Atrial flutter with 2:1 atrioventricular block, an atrial rate of 430 beats per minute.
B. Atrial tachycardia with 2:1 atrioventricular block.
C. Right ventricular hypertrophy.
D. Left ventricular hypertrophy.
E. Findings compatible with a ventricular septal defect.

**2. Management of this young patient could include:**

A. Digitalis.
B. Quinidine.
C. DC cardioversion.
D. Cardiac catheterization.
E. All of the above.

*(Continued on page 46)*

Blue Cross®
Blue Shield®

# REPORT

FOR *Illinois Physicians*

## Health Care Achievement Awards

Dear Doctor:

Critics contend that the private health care sector talks about its problems, but rarely does anything positive about them.

The media, government, consumer groups and others demand results. Congressman Dan Rostenkowski (D., Ill.) who, by virtue of being Chairman of the Health Subcommittee of the Committee on Ways and Means, can help change the course of our health care system, put it this way: " The health care industry must recognize that if it proves unwilling or unable to immediately address the problem of rising costs, it cannot reasonably object to government initiatives."

The 1978 Blue Cross and Blue Shield Symposium on November 15 is designed to demonstrate that the private health care sector not only can, but is tackling its problems. This will be achieved by recognizing initiatives that have been made by the private sector in dealing with areas of health costs, quality and/or accessibility. This recognition will bring a great deal of public attention to the initiatives that are being carried out by the private sector—placing the private sector in a far more favorable light than it is currently perceived!

You are invited to tell us about your actions that are designed to have a positive impact on the cost, quality and/or accessibility of health care services.

The entries will be judged by a five-member panel comprised of representatives from the Illinois Hospital Association, Illinois State Medical Society, Chicago Hospital Council, Chicago Medical Society and the Illinois Clinic Managers Association.

Entries will be divided into three groups with awards being given in each category. The groups include hospitals, physicians and employers.

Full details of the competition and how to complete an entry appear on this page in the adjoining column.

We hope that you will submit an entry because we believe that our Symposium III will do much to rebuild confidence in the private health care sector.

Sincerely,
Richard F. O'Connell
Vice President
Public Affairs
Blue Cross and Blue Shield

The purpose of the Health Care Achievement Awards is to demonstrate that the private sector is making significant progress in dealing with the issues of health care costs, quality and/or accessibility as well as to give deserved recognition to those individuals, institutions and employers responsible for outstanding achievements in these areas.

Health Care Achievement Awards will be presented in three categories: hospitals, physicians and employers. For physicians, the three categories are solo practitioners, group practices and prepaid groups practices (including foundations for medical care). Clinic managers, along with medical directors, may be cited in the case of group practices and prepaid groups.

Entries will be judged on the impact a described program or effort has made on the cost, quality and/or accessibility of health care services. An award, for example, might be given for a program that promotes a less costly type of health care without sacrificing quality such as an out-patient surgical program. An award could be given for the establishment of a medical clinic in a rural area that would improve the accessibility of health care services for area residents. A third example would be an award for an employee physical fitness program.

The panel of judges will contact you if additional information is required after an entry is submitted. For further details on the Health Care Achievement Awards, please contact Doreen Molloy at (312) 661-4279.

Entries should be mailed to Health Care Achievement Awards, 14th Floor, Blue Cross and Blue Shield, 233 North Michigan Avenue, Chicago, Illinois 60601.

Entries must be received by September 15, 1978.

## Name of Physician Important On Medicare Claim

In order to process a Medicare claim, it is essential that the physician who rendered the service is identified by his first and last name. The name of the group, or a listing of the physicians in the group, *is not sufficient information* for identification since each physician is assigned his own Medicare provider number.

When the multiple listing billing form is used, the name of the *specific physician who rendered the service* should be underlined in ink or bold pencil, circled or otherwise precisely identified on the bill.

The best method of identification is to affix the physician's imprinted Medicare label on the bill, available from the Medicare carrier. Identification of the physician is especially important following the passage of the Sunshine Act by the government, since it permits the public disclosure of Medicare payments to physicians.

Failure to provide proper physician identification results in the delay of the claim and perhaps payments listed erroneously as having been made to a particular physician.

## Gallium-67 Citrate Scan

This diagnostic procedure involves the use of Gallium-67 Citrate in demonstrating the presence and extent of such malignancies as lymphomas, Hodgkins disease and bronchogenic carcinoma.

Program payment may be made for medical imaging procedures when performed with Gallium-67 Citrate, if the scan is performed with Gallium-67 Citrate produced by a manufacturer that has FDA approval for this radiopharmaceutical, and, if the scan is also reasonable and necessary for the individual patient. To date, the FDA has only approved this radiopharmaceutical as manufactured by the New England Nuclear Corporation (effective May 17, 1976) and Diagnostic Isotopes, Inc., (effective December 16, 1977). If the FDA approves Gallium-67 Citrate produced by other manufacturers, payment may also be made for scans performed on or after the effective date of approval, which utilize Gallium-67 Citrate produced by such manufacturers.

## Changes in Participation and Certification of Laboratory Procedures

Notices were received from the Medicare Bureau of the following changes in participation and certification of procedures of laboratories in the Medicare program:

**Approved for Participation:**

Dav-Kim Portable X-Ray, 409 Barnsley Place, Northbrook, Illinois 60062 (Provider Number 14-9817) has been approved as a supplier of portable X-ray services under the Medicare program. The effective date of coverage is January 23, 1978.

Liberty Portable X-Ray, 5339 South Major, Chicago 60638 (Provider Number 14-9816) has been approved as a supplier of portable X-ray services under the Medicare program. The effective date of coverage is July 25, 1977.

**Notification of Closing:**

Peterson Clinical Laboratory, 2424 West Peterson, Chicago 60645 (Provider Number 14-8159) closed, effective April 30, 1978. No payment can be made under the health insurance program for services rendered on or after the effective closing date.

**Changes in Approved Procedures:**

Bowers Laboratory, 7318 Madison Street, Forest Park is no longer approved to perform Procedure 330-Chemistry-Other, effective May 1, 1978. The laboratory is still approved to perform procedures in Bacteriology, Parasitology, Serology, Routine Chemistry, Clinical Microscopy, Blood Group and Rh. Rh Titers, Hematology, and EKG Services.

F & M Medical Laboratory, Inc., 4554 North Broadway, Chicago is no longer approved to perform Procedure 130-Parasitology, 330-Chemistry-Other, and 710-EKG Services. These deletions are effective May 1, 1978. The laboratory is still approved to perform procedures in Bacteriology, Serology, Chemistry-Routine, Clinical Microscopy, Hematology, and Blood Group & Rh.

Royal Medical Laboratory, 3940 West Division Street, Chicago is no longer approved to perform Procedures 120-Mycology; 130-Parasitology; and 510 Rh Typing. The deletions were effective April 13, 1978. The laboratory is still approved to perform procedures in Serology, Chemistry-Routine; Clinical Mycroscopy, Hematology and Diagnostic Cytology.

Clearing Industrial Clinic, 5548 West 55th Street, Chicago is no longer approved to perform Procedure 330-Chemistry-Other, effective April 13, 1978. The laboratory is approved to perform procedures in Serology, Routine Chemistry, Clinical Microscopy and Hematology.

Franklin Park Medical Laboratory, Inc., 9711 West Grand, Franklin Park, Illinois 60131 is no longer approved to perform Procedure 330-Chemistry-Other. The laboratory is approved to perform Procedures 400-Hematology and 710-EKG services.

# What's new at Bio-Science Chicago?



## Always the latest specialized diagnostic tests.

**Chemistry**
Anti-convulsant group
Cadmium in blood
Darvon®
Ferritin in serum
Free erythrocyte protoporphyrins
Pyridoxal phosphate ($B_6$)
Riboflavin ($B_2$)
Succinimides in serum
Theophylline
Uroporphyrinogen-1-synthetase
Clonopin®

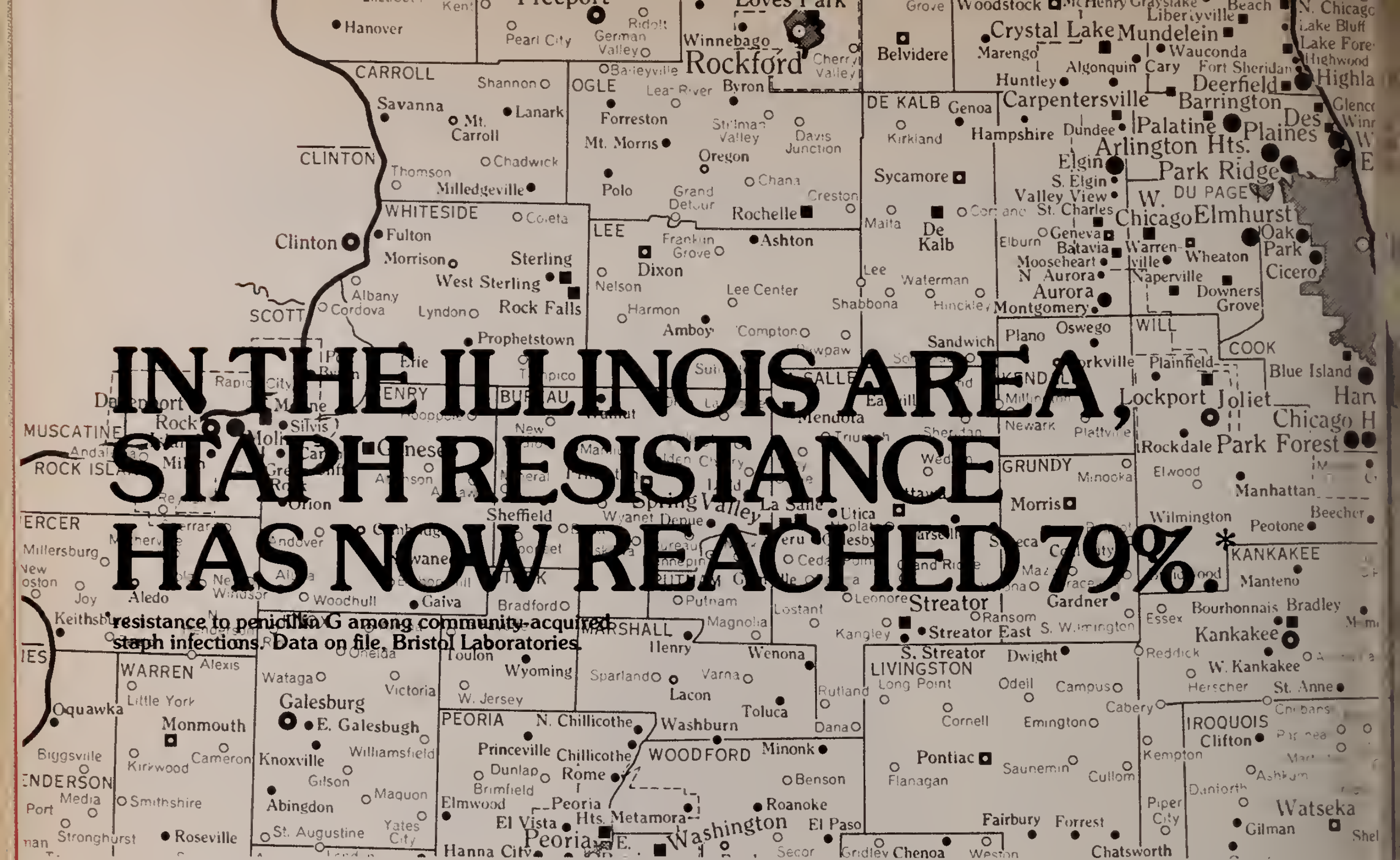
**Endocrinology**
Androstenedione in serum
Calcitonin
C-Peptide
Estriol in serum
Placental Estriol in urine
HCG-$\beta$-subunit
Pregnanetriol in urine (GLC)
Prolactin
17-OH Progesterone in serum
Thyroglobulin in serum
25-Hydroxy Vitamin D
Estradiol Receptor Assay by Scatchard Plot
Progesterone Receptor Assay

**Immunochemistry**
Anti-extractable nuclear antigen (Anti-ENA)
Fungus antibody group
Gentamicin
Intrinsic factor antibodies
Tobramycin
Anti-tissue antibodies
HLA-B27

Bio-Science

**Bio-Science Laboratories**

Chicago Branch
770 Burr Oak Drive
Westmont, Il 60559
(312) 887-9800




# IN THE ILLINOIS AREA, STAPH RESISTANCE HAS NOW REACHED 79%.*

*resistance to penicillin G among community-acquired staph infections. Data on file, Bristol Laboratories.

## WHEN YOU CAN'T RULE OUT STAPH, CONSIDER

# TEGOPEN®
# (cloxacillin sodium)

## ..."THE PENICILLIN OF TODAY"

- Effective against nonpenicillinase-producing staphylococci, beta-hemolytic streptococci, and pneumococci.†

†NOTE: The choice of Tegopen should take into consideration the fact that it has been shown to be effective only in the treatment of infections caused by pneumococci, Group A beta-hemolytic streptococci, and penicillin G-resistant and penicillin G-sensitive staphylococci. If the bacteriology report later indicates that the infection is due to an organism other than a penicillin G-resistant staphylococcus sensitive to cloxacillin sodium, the physician is advised to continue therapy with a drug other than cloxacillin sodium or any other penicillinase-resistant semisynthetic penicillin. The clinical significance of *in vitro* data is unknown.

- 10 times more active against strep than staph.

- Well absorbed from the G.I. tract.‡

‡Maximum absorption occurs when Tegopen is taken on an empty stomach, preferably 1-2 hrs. before meals.



Please see brief summary for prescribing information.

**Brief Summary of Prescribing Information**
**Combined TEGOPEN® (cloxacillin sodium)**
**Capsules and Oral Solution**
For complete information, consult Official Package Circular. (12) TEGOPEN 9/11/75

**Indications:** Although the principal indication for cloxacillin sodium is in the treatment of infections due to penicillinase-producing staphylococci, it may be used to initiate therapy in such patients in whom a staphylococcal infection is suspected. (See Important Note below.)

Bacteriologic studies to determine the causative organisms and their sensitivity to cloxacillin sodium should be performed.

**Important Note:** When it is judged necessary that treatment be initiated before definitive culture and sensitivity results are known, the choice of cloxacillin sodium should take into consideration the fact that it has been shown to be effective only in the treatment of infections caused by pneumococci, Group A beta-hemolytic streptococci, and penicillin G-resistant and penicillin G-sensitive staphylococci. If the bacteriology report later indicates the infection is due to an organism other than a penicillin G-resistant staphylococcus sensitive to cloxacillin sodium, the physician is advised to continue therapy with a drug other than cloxacillin sodium or any other penicillinase-resistant semi-synthetic penicillin.

Recent studies have reported that the percentage of staphylococcal isolates resistant to penicillin G outside the hospital is increasing, approximating the high percentage of resistant staphylococcal isolates found in the hospital. For this reason, it is recommended that a penicillinase-resistant penicillin be used as initial therapy for any suspected staphylococcal infection until culture and sensitivity results are known.

Cloxacillin sodium is a compound that acts through a mechanism similar to that of methicillin against penicillin G-resistant staphylococci. Strains of staphylococci resistant to methicillin have existed in nature and it is known that the number of these strains reported has been increasing. Such strains of staphylococci have been capable of producing serious disease, in some instances resulting in fatality. Because of this, there is concern that widespread use of the penicillinase-resistant penicillins may result in the appearance of an increasing number of staphylococcal strains which are resistant to these penicillins.

Methicillin-resistant strains are almost always resistant to all other penicillinase-resistant penicillins (cross-resistance with cephalosporin derivatives also occurs frequently). Resistance to any penicillinase-resistant penicillin should be interpreted as evidence of clinical resistance to all, in spite of the fact that minor variations in *in vitro* sensitivity may be encountered when more than one penicillinase-resistant penicillin is tested against the same strain of staphylococcus.

**Contraindications:** A history of a previous hypersensitivity reaction to any of the penicillins is a contraindication.

**Warning:** Serious and occasionally fatal hypersensitivity (anaphylactoid) reactions have been reported in patients on penicillin therapy. Although anaphylaxis is more frequent following parenteral therapy it has occurred in patients on oral penicillins. These reactions are more apt to occur in individuals with a history of sensitivity to multiple allergens.

There have been well documented reports of individuals with a history of penicillin hypersensitivity reactions who have experienced severe hypersensitivity reactions when treated with a cephalosporin. Before therapy with a penicillin, careful inquiry should be made concerning previous hypersensitivity reactions to penicillins, cephalosporins, and other allergens. If an allergic reaction occurs, the drug should be discontinued and the patient treated with the usual agents, e.g., pressor amines, antihistamines, and corticosteroids.

Safety for use in pregnancy has not been established.

**Precautions:** The possibility of the occurrence of superinfections with mycotic organisms or other pathogens should be kept in mind when using this compound, as with other antibiotics. If superinfection occurs during therapy, appropriate measures should be taken.

As with any potent drug, periodic assessment of organ system function, including renal, hepatic, and hematopoietic, should be made during long-term therapy.

**Adverse Reactions:** Gastrointestinal disturbances, such as nausea, epigastric discomfort, flatulence, and loose stools, have been noted by some patients. Mildly elevated SGOT levels (less than 100 units) have been reported in a few patients for whom pretherapeutic determinations were not made. Skin rashes and allergic symptoms, including wheezing and sneezing, have occasionally been encountered. Eosinophilia, with or without overt allergic manifestations, has been noted in some patients during therapy.

**Usual Dosage:** Adults: 250 mg. q.6h.

Children: 50 mg./Kg./day in equally divided doses q.6h. Children weighing more than 20 Kg. should be given the adult dose. Administer on empty stomach for maximum absorption.

*N.B.:* INFECTIONS CAUSED BY GROUP A BETA-HEMOLYTIC STREPTOCOCCI SHOULD BE TREATED FOR AT LEAST 10 DAYS TO HELP PREVENT THE OCCURRENCE OF ACUTE RHEUMATIC FEVER OR ACUTE GLOMERULONEPHRITIS.

**Supplied:** Capsules—250 mg. in bottles of 100, 500 mg. in bottles of 100. Oral Solution—125 mg./5 ml. in 100 ml. and 200 ml. bottles.

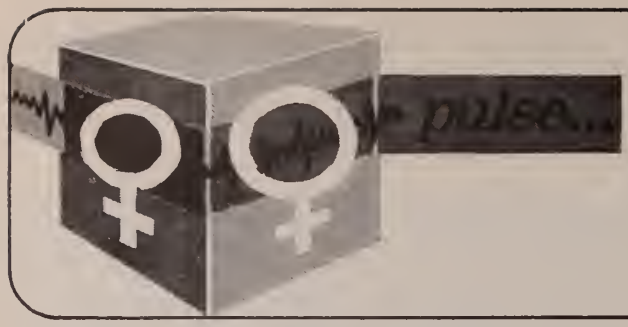
BRISTOL®
BRISTOL LABORATORIES
Division of Bristol-Myers Company
Syracuse, New York 13201

# Clinics for Crippled Children Listed for August

Twenty-nine clinics for Illinois' physically handicapped children have been scheduled for August by the University of Illinois, Division of Services for Crippled Children. The Division will count nineteen general clinics providing diagnostic orthopedic, pediatric, speech and hearing examination, along with medical social and nursing services. There will be nine special clinics for children with cardiac conditions and one for children with cerebral palsy. Any private physician may refer to or bring to a convenient clinic any child or children for whom he may want examination or consultative services.

August 1 Park Ridge Cardiac—Lutheran General Hospital
August 2 Hinsdale—Hinsdale Sanitarium
August 3 Sterling—Community General Hospital
August 3 Lake County Cardiac—Victory Memorial Hospital
August 4 Division Cardiac—U. of I. at the Medical Center
August 8 Peoria—St. Francis Hospital
August 8 East St. Louis—Christian Welfare Hospital
August 9 Rockford—St. Anthony's Hospital
August 9 Champaign—McKinley Hospital
August 9 Joliet—St. Joseph's Hospital
August 10 Springfield—St. John's Hospital
August 10 Kankakee General—St. Mary's Hospital
August 11 Chicago Heights Cardiac—St. James Hospital
August 14 Peoria Cardiac—St. Francis Hospital
August 15 Rock Island—Moline Public Hospital
August 15 Belleville—St. Elizabeth's Hospital
August 16 Springfield Ped-Neuro—St. John's Hospital
August 16 Chicago Heights General—St. James Hospital
August 17 Rockford—Rockford Memorial Hospital
August 17 Bloomington—Mennonite Hospital
August 17 Elmhurst Cardiac—Memorial Hospital of DuPage County
August 18 Kankakee Cardiac—St. Mary's Hospital
August 21 Maywood—Loyola Medical Center
August 22 Peoria—St. Francis Hospital
August 23 Aurora MM—St. Joseph Mercy Hospital
August 24 Litchfield—St. Francis Hospital
August 25 Evanston—St. Francis Hospital
August 25 Chicago Heights Cardiac—St. James Hospital
August 28 Peoria Cardiac—St. Francis Hospital

The Division of Services for Crippled Children is the official state agency established to provide medical, surgical, corrective and other services and facilities for diagnosis, hospitalization and after-care for children with crippling conditions or who are suffering from conditions that may lead to crippling. In carrying on its program, the Division works cooperatively with local medical societies, hospitals, the Illinois Children's Hospital-School, civic and fraternal clubs, visiting nurse association, local social and welfare agencies, local chapters of the National Foundation and other interested groups. In all cases, the work of the Division is intended to extend and supplement, not supplant, activities of other agencies, either public or private, state or local, carried on in behalf of crippled children.




# of the ISMS auxiliary

Mrs. Eugene Vickery, Editor

## *Growth Patterns*

# New Officers Introduced



Mrs. Earl V. Klaren, President, ISMSA

The Illinois State Medical Society Auxiliary elected three new vice presidents at the April meeting: Mrs. Harlan Failor, Mrs. Don Hinderliter and Mrs. Harold Keegan.

Pat Failor, First Vice President (Membership) will be responsible for encouraging new memberships. Pat has been a member of the ISMSA Board of Directors for seven years. She has served as Public Affairs Chairman, a Director, (responsible for members-at-large) Treasurer, Third Vice President (Communications) and president of the Champaign County Medical Auxiliary.

As Second Vice President (Programs), Mrs. Don Hinderliter is available to county medical society auxiliaries with pertinent information and will serve as our liaison with the AMA Auxiliary Project Bank. Diane holds degrees from Northern Illinois University and the Rockford Memorial School of Nursing. She served as president of the Ogle County Medical Auxiliary, 1975-78, and ISMSA State Health Education and Health Manpower Chairman in 1976-77. Diane's husband Doctor Don Hinderliter, a family practitioner, is currently ISMS Public Affairs Committee Chairman.



**Pictured above, top row, l-r, First Vice President Pat Failor and Director Jean Hodges. Bottom row, Diane Hinderliter, Second Vice President and Third Vice President Bonnie Keegan.**

Mrs. Harold Keegan, Third Vice President (Communications) will assist constituent auxiliaries in communications efforts and publications. Bonnie, who edited *PULSE* for three years and is the immediate past Community Health Chairman, is well-versed in public relations. Bonnie and her husband, Doctor Harold Keegan, a neurosurgeon, live in Kankakee with their four children. She is the former president of the Kankakee County Auxiliary, as well as chairman of community health and special projects.

Our new vice presidents are anxious to help county efforts. Please call upon them to help you make the most of auxiliary involvement. Better yet, take advantage of the opportunity to meet them at Fall Conference in September.



report

Illinois Society
American Association of Medical Assistants

# *Medical Records and Patient Care To Highlight Annual Symposium*

By Magda Brown, Chairman, Public Relations

The American Association of Medical Assistants, Illinois Society, will hold an all-day educational program on Sunday, September 17, 1978. The program will be held at the Continental Regency Hotel, 500 Hamilton Blvd., Peoria, from 9 a.m. until 4 p.m.

The symposium represents an annual culmination of daily efforts to define and disseminate an understanding of the nature and function of the medical office staff.

Physician-employers are asked to encourage their office staff to attend this diversified, educational program. The program, coordinated by the Peoria Chapter, is designed to be of interest to medical personnel in all capacities.

Application has been filed with the American Association of Medical Assistants for CEU (continuing education unit) credits.

Following registration and coffee at 8:30 a.m., the morning segment will be devoted to the importance of accurate medical record keeping in the doctor's office. A medical record instructor will explore the number one phase of record keeping: confidentiality.

A slide presentation on rare diseases of the ears, nose and throat will accompany a lecture on treatment and office care. The speaker for this segment is a well known ENT specialist.

The afternoon segment following noon luncheon will deal with office surgery. Changes and improvements in general and thoracic surgery as well as handling the post surgical patient in the office will be discussed by a panel of prominent surgeons.

Miss Pauline Klarich, chairman, and members of the Peoria chapter will welcome registrants at a hospitality-welcome party on Saturday, September 16, 1978 at 6:30 p.m. in the hotel. Refreshments will be served.

Registration package includes refreshment Saturday evening, coffee/rolls Sunday morning and luncheon Sunday noon, in addition to the all day educational seminar.

Advanced registration for members before September 1, 1978 will cost $12.50. Member registration after that date is $15.00. Students will be charged $6.00, and non-members, $15.00. (Registrants are advised to contact the hotel in advance for overnight accommodations.)

Please complete the coupon below and mail to: Mrs. Mary Palmer, 1925 W. Calendar Street, Peoria, Ill. 61604. (309) 676-5438. Make check payable to: AAMA, Illinois Society, Symposium.

---

"The Pocketbook of Knowledge"

_____ Member of AAMA: ____/____
Name yes no

_____
Address

# *Obituaries*

**°°Alvarez, Walter C.**, San Francisco, California, died June 18, 1978, at the age of 93. He was a 1905 graduate of Cooper Medical College, San Francisco. Dr. Alvarez practiced medicine for 70 years, and formerly wrote a medical column for the Chicago Sun-Times.

**°°Bond, Ian H.**, Ormond Beach, Florida, died October 28, 1977 at the age of 80. Dr. Bond was a 1928 graduate of Rush Medical School.

**°°Colwell, Arthur**, Evanston, died June 14, 1978, at the age of 80. A 1922 graduate of Rush Medical College, Dr. Colwell was chairman of Northwestern University Medical School's department of medicine for 15 years. In his long association with Northwestern Memorial Hospital, Dr. Colwell practiced internal medicine and was named president of the American Diabetes Association in 1955. Dr. Colwell was a founder and president of the Chicago Diabetes Association.

**°Elmer, Raymond F.**, Colorado, died June 4, 1978, at the age of 86. Dr. Elmer was a 1915 Chicago Medical School graduate.

**°°Garside, Earl**, Chicago, died June 7, 1978, at the age of 78. He was a 1923 graduate of the University of Oklahoma. Dr. Garside was a surgeon and former chief of staff at Augustana Hospital.

**°Goldstein, I. Irwin**, Chicago, died May 23, 1978, at the age of 64. Dr. Goldstein was a 1939 graduate of Stritch School of Medicine.

**°Hastings, J. W.**, Aledo, died June 5, 1978, at the age of 62. He was a 1942 graduate of the University of Illinois, Abraham Lincoln School of Medicine. Dr. Hastings had held many offices in the Mercer County Medical Society, and served as secretary at the time of his death. He was also the chief of surgery at Mercer County Hospital.

**°Karg, Frank P.**, Western Springs, died May 18, 1978.

**°°Kenyon, Allan T.**, Chicago, died May 26, 1978, at the age of 77. He was a 1926 graduate of Rush Medical College. Dr. Kenyon was professor emeritus at the Pritzker School of Medicine. At the time of his retirement in 1966, Dr. Kenyon was head of the department of endocrinology.

**Kirson, Celia**, New York, died June 18, 1978, at the age of 85. Dr. Kirson was an attending psychiatrist at Manteno State Hospital.

**°Lang, Theodore**, Rockford, died April 12, 1978, at the age of 73. He was a 1929 graduate of the University of Vienna, Austria. Dr. Lang was formerly affiliated with St. Ann's Hospital, 1933-1972, and served as head of the department of radiology.

**°°Lenit, Oscar**, Florida, died May 30, 1978, at the age of 88. A 1914 graduate of the University of Illinois, Dr. Lenit was formerly on the staff of American Hospital.

**°Slaughter, Wayne B.**, Idaho, died June 21, 1978, at the age of 70. A 1934 graduate of the University of Nebraska and former Chicago surgeon, Dr. Slaughter served as a faculty member at Loyola University. He was also chairman of the department of plastic surgery at Mercy Hospital.

**°Steinberg, D. Louis**, Elgin, died April 27, 1978, at the age of 75. Dr. Steinberg graduated from the University of Illinois in 1931.

**°Strauser, Emory Ross**, Dixon, died May 16, 1978, at the age of 82. Dr. Strauser was a 1932 graduate of the University of Chicago, Pritzker School of Medicine.

**°°Sugar, Roy Thomas**, Chicago, died May 12, 1978, at the age of 82. He was a 1926 graduate of the University of Illinois, Abraham Lincoln School of Medicine.

**°Suslick, Alvin**, Evanston, died May 22, 1978, at the age of 53. Dr. Suslick was a 1950 graduate of the University of Illinois.

**°°Thiell, James E.**, Rockford, died May 23, 1978, at the age of 87. Dr. Thiell was a 1915 graduate of the University of Illinois.

**°Urban, Francis E.**, Chicago, died December 11, 1977, at the age of 71. Dr. Urban was a 1933 graduate of the Stritch School of Medicine.

**°°Welden, Edmund A.**, Summit, died January 21, 1978, at the age of 91. Dr. Welden was a 1917 graduate of the University of Illinois.

**°°Zaus, Earl Alfred**, Chicago, died April 21, 1978, at the age of 82. He was a 1922 graduate of Rush Medical School and was formerly affiliated with Cook County Hospital.

**°Zeller, Michael**, Skokie, died November 5, 1977, at the age of 78. Dr. Zeller was a 1925 graduate of Northwestern University Medical School.

*°Indicates ISMS member.*
*°°Indicates member of the ISMS Fifty Year Club.*




# Tolinase®
## tolazamide, Upjohn

Please contact your Upjohn representative for additional product information.

Upjohn

J-5695-6

©1977 THE UPJOHN COMPANY



Only Jobst supports are custom made from precise measurements of the individual extremity.

# Jobst®
# Venous Pressure Gradient® Supports

These measured, custom-made therapeutic elastic supports have carried the Jobst name to the four corners of the world. Prescription only, the supports can be engineered with counterpressures of 25, 30, 40 or 50 mm.Hg at the ankle, decreasing proximally along the venous pressure gradient. They are available in knee-length, full-leg, waist-height and lymphedema sleeve styles. The waist-height Jobst Pregnancy Leotard deserves special mention because each one is custom made with an expandable panel according to the patient's own measurements.

**Contact your local Jobst Service Center for complete details.**

## JOBST CHICAGO SERVICE CENTER

**Chicago, Illinois 60602**
Suite 2101, Pittsfield Bldg.
55 E. Washington Street
312/346-0446



**"I'm just a shadow of what I used to be."**

That is what depressed individuals may feel is the substance of their being. There is no pleasure, no joy — nothing grows — and in the cold shadow of depression their activities are inhibited, while initiative may be eroded or destroyed. The tragedy is that they can see that others are able to live on the brighter side but they, themselves, cannot reach it on their own.

Your experience in treating depression, and Tofranil-**PM** can help light the way.

# Tofranil-**PM**®
imipramine **pamoate**

Geigy

## Unsurpassed effectiveness among tricyclics in relieving symptoms of anxious depression.

Before prescribing Tofranil-PM, please review a summary of the prescribing information on the back of this page.

# Tofranil-**PM**®
imipramine **pamoate**

Geigy

As anxiety, agitation, sleep disturbances, and other depressive symptoms are relieved, mood and motivation may be markedly improved.

Patients are usually alert and capable of functioning at more normal levels of behavior.

Tofranil-PM encourages patient compliance because one capsule lasts from bedtime to bedtime.

Good results are usually seen at the starting dose of one 75-mg capsule h.s.

For many patients, dosage can be safely increased to 150 mg daily.

As with all tricyclics, sedation may occur. Please caution patients against driving or op- ating dangerous machinery.

Each capsule contains imipramine pamoate equiva to 75, 100, 125 or 150 mg of imipramine hydrochloride.

**Tofranil-PM®**
**brand of imipramine pamoate**

**Indications:** For the relief of symptoms of depression. Endogenous depression is more likely to be alleviated than other depressive states.

**Contraindications:** The concomitant use of monoamine oxidase inhibiting compounds is contraindicated. Hyperpyretic crises or severe convulsive seizures may occur in patients receiving such combinations. The potentiation of adverse effects can be serious, or even fatal. When it is desired to substitute Tofranil-PM, brand of imipramine pamoate, in patients receiving a monoamine oxidase inhibitor, as long an interval should elapse as the clinical situation will allow, with a minimum of 14 days. Initial dosage should be low and increases should be gradual and cautiously prescribed. The drug is contraindicated during the acute recovery period after a myocardial infarction. Patients with a known hypersensitivity to this compound should not be given the drug. The possibility of cross-sensitivity to other dibenzazepine compounds should be kept in mind.

**Warnings:** *Usage in Pregnancy:* Safe use of imipramine during pregnancy and lactation has not been established; therefore, in administering the drug to pregnant patients, nursing mothers, or women of childbearing potential, the potential benefits must be weighed against the possible hazards. Animal reproduction studies have yielded inconclusive results. There have been clinical reports of congenital malformation associated with the use of this drug, but a causal relationship has not been confirmed.

Extreme caution should be used when this drug is given to:

—patients with cardiovascular disease because of the possibility of conduction defects, arrhythmias, myocardial infarction, strokes and tachycardia;

—patients with increased intraocular pressure, history of urinary retention, or history of narrow-angle glaucoma because of the drug's anticholinergic properties;

—hyperthyroid patients or those on thyroid medication because of the possibility of cardiovascular toxicity;

—patients with a history of seizure disorder because this drug has been shown to lower the seizure threshold;

—patients receiving guanethidine or similar agents since imipramine may block the pharmacologic effects of these drugs.

Since imipramine may impair the mental and/or physical abilities required for the performance of potentially hazardous tasks such as operating an automobile or machinery, the patient should be cautioned accordingly.

*Usage in Children:* Tofranil-PM, brand of imipramine pamoate, should not be used in children of any age because of the increased potential for acute overdosage due to the high unit potency (75 mg., 100 mg., 125 mg. and 150 mg.). Each capsule contains imipramine pamoate equivalent to 75 mg., 100 mg., 125 mg. or 150 mg. imipramine hydrochloride.

**Precautions:** It should be kept in mind that the possibility of suicide in seriously depressed patients is inherent in the illness and may persist until significant remission occurs. Such patients should be carefully supervised during the early phase of treatment with Tofranil-PM, brand of imipramine pamoate, and may require hospitalization. Prescriptions should be written for the smallest amount feasible.

Hypomanic or manic episodes may occur, particularly in patients with cyclic disorders. Such reactions may necessitate discontinuation of the drug. If needed, Tofranil-PM, brand of imipramine pamoate, may be resumed in lower dosage when these episodes are relieved. Administration of a tranquilizer may be useful in controlling such episodes.

Prior to elective surgery, imipramine should be discontinued for as long as the clinical situation will allow.

An activation of the psychosis may occasionally be observed in schizophrenic patients and may require reduction of dosage and the addition of a phenothiazine.

In occasional susceptible patients or in those receiving anticholinergic drugs (including antiparkinsonism agents) in addition, the atropine-like effects may become more pronounced (e.g., paralytic ileus). Close supervision and careful adjustment of dosage is required when this drug is administered concomitantly with anticholinergic or sympathomimetic drugs.

Avoid the use of preparations, such as decongestants and local anesthetics, which contain any sympathomimetic amine (e.g., adrenalin, noradrenalin), since it has been reported that tricyclic antidepressants can potentiate the effects of catecholamines.

Patients should be warned that the concomitant use of alcoholic beverages may be associated with exaggerated effects.

Both elevation and lowering of blood sugar levels have been reported.

Concurrent administration of imipramine with electroshock therapy may increase the hazards; such treatment should be limited to those patients for whom it is essential, since there is limited clinical experience.

**Adverse Reactions:** Note: Although the listing which follows includes a few adverse reactions which have not been reported with this specific drug, the pharmacological similarities among the tricyclic antidepressant drugs require that each of the reactions be considered when imipramine is administered.

*Cardiovascular:* Hypotension, hypertension, tachycardia, palpitation, myocardial infarction, arrhythmias, heart block, stroke, falls.

*Psychiatric:* Confusional states (especially in the elderly) with hallucinations, disorientation, delusions; anxiety, restlessness, agitation; insomnia and nightmares; hypomania; exacerbation of psychosis.

*Neurological:* Numbness, tingling, paresthesias of extremities; incoordination, ataxia, tremors; peripheral neuropathy; extrapyramidal symptoms; seizures, alterations in EEG patterns; tinnitus.

*Anticholinergic:* Dry mouth, and, rarely, associated sublingual adenitis; blurred vision, disturbances of accommodation, mydriasis; constipation, paralytic ileus; urinary retention, delayed micturition, dilation of the urinary tract.

*Allergic:* Skin rash, petechiae, urticaria, itching, photosensitization (avoid excessive exposure to sunlight); ed (general or of face and tongue); drug fever; cross-sensitivity with desipramine.

*Hematologic:* Bone marrow depression including ag ulocytosis; eosinophilia; purpura; thrombocytopenia Leukocyte and differential counts should be perform any patient who develops fever and sore throat dur therapy; the drug should be discontinued if there is dence of pathological neutrophil depression.

*Gastrointestinal:* Nausea and vomiting, anorexia, ep tric distress, diarrhea; peculiar taste, stomatitis, abd cramps, black tongue.

*Endocrine:* Gynecomastia in the male; breast enlar ment and galactorrhea in the female; increased or d creased libido, impotence; testicular swelling; eleva depression of blood sugar levels.

*Other:* Jaundice (simulating obstructive); altered liv function; weight gain or loss; perspiration; flushing; nary frequency; drowsiness, dizziness, weakness a fatigue; headache; parotid swelling; alopecia.

*Withdrawal Symptoms:* Though not indicative of ad abrupt cessation of treatment after prolonged thera may produce nausea, headache and malaise.

**Dosage and Administration:** In adult outpatients therapy should be initiated on a once-a-day basis v mg./day. This may be increased to 150 mg./day wh the dose level which usually obtains optimum respo necessary, dosage may be increased to 200 mg./d. Dosage should be modified as necessary by clinica sponse and any evidence of intolerance. Daily dosa may be given at bedtime, or in some patients in div daily doses.

Hospitalized patients should be started on a once-a basis with 100-150 mg./day and may be increased mg./day. Dosage should be increased to 250-300 m if there is no response after two weeks.

Following remission, maintenance medication may quired for a longer period of time at the lowest dosa will maintain remission. The usual adult maintenan dosage is 75-150 mg./day on a once-a-day basis, p ably at bedtime.

In adolescent and geriatric patients, capsules of To PM, brand of imipramine pamoate, may be used w total daily dosage is established at 75 mg. or highe generally unnecessary to exceed 100 mg./day in th patients. This dosage may be given once a day at time or, if needed, in divided daily doses.

**How Supplied:** Tofranil-PM, brand of imipramine pamoate: Capsules of 75, 100, 125 and 150 mg. (E capsule contains imipramine pamoate equivalent t 100, 125 or 150 mg. of imipramine hydrochloride.)
(B) 98-146-840-A(9/75) 667120

**For complete details, including dosage and adm tration, please refer to the full prescribing infor**

GEIGY Pharmaceuticals
Division of CIBA-GEIGY Corporation
Ardsley, New York 10502

Printed in U.S.A. (10-77) TO 12889

# Manuscript Information

The *IMJ* solicits original articles of clinical interest to the medical profession. Manuscripts should ordinarily be limited to 12-16 pages double spaced, with one inch margins. Case reports also are welcome; these, however, should be limited to 2,000 words (allowing equivalent space for charts and illustrations). Lengthy reviews of the literature also are welcome, but these may be serialized. Authors are requested to indicate an appropriate "breaking point" for long articles.

Up to twenty references will be published for clinical manuscripts; a maximum of ten are permitted for case reports. *Please* follow *Journal* style in your references. They should be numbered in order of appearance. The style is as follows: author name(s), article title, source periodical, volume, page, and date of publication.

The Journal cannot accept responsibility for accuracy of text or references.

The first page of each manuscript should show the title, authors, author degrees, positions, and mailing addresses. All manuscripts should be typed, double spaced, and submitted in duplicate. Illustrations should be drawn in india ink or photographed as black-and-white glossies. Number illustrations consecutively and mark the top of each, as well as your name, on the back.

On the second page, please give a brief summary of content.

If you are not interested in writing an article for the *Journal,* why not at least communicate your thoughts and clinical notes to the "Membership Forum" section? And don't forget our new feature, "Ask A Consult," starting next month.

All correspondence should be addressed to: J. William Roddick, M.D., Chairman, IMJ Editorial Board, 55 E. Monroe Street, Suite 3510, Chicago 60603.


**LOW-COST GROUP INSURANCE ANOTHER ISMS MEMBERSHIP PRIVILEGE**

**THE GROUP DISABILITY PLAN** ● Provides up to $1,732.00 monthly in the event of disability caused by Accident or Sickness. ● Special Guaranteed renewal feature. ● Protect your income and security.

**BUSINESS OVERHEAD EXPENSE PLAN** ● Pays your office overhead expense when disability strikes. ● Premiums are Tax Deductible. ● Pays in Addition to the Disability Plan Benefits.

**THE BASIC MAJOR MEDICAL EXPENSE PLAN** ● In or out of Hospital Benefits up to $25,000.00 per Disability. ● Up to $100.00 Daily Hospital Room and Board maximum. ● Subject to choice of deductible and 80% coinsurance.

**EXCESS MAJOR MEDICAL PLAN** ● Provides up to $500,000 for Medical Expenses. ● Supplements any Basic Major Medical Plan and is available with a $15,000, $20,000 and $25,000 deductible. Low group rates. ● Truly catastrophic coverage.

FOR INFORMATION, ASSISTANCE & DETAILS CONTACT:

Administrators:
PARKER, ALESHIRE & COMPANY
ESTABLISHED 1901
Insurance

9933 N. Lawler Avenue
Skokie, Illinois 60077
Phone: 312-679-1000

## *Rheumatology Rounds*

L. F. Layfer, M.D., and J. V. Jones, M.D., Contributing Co-Editors

# Painful Anterior Shoulder Mass With Calcification

A 61-year-old housewife presented with a painful anterior shoulder mass. Four months previously she had noted onset of right shoulder pain while lifting groceries. The symptoms were exacerbated by forward flexion of the arm. Gradually range of motion became restricted in all directions due to severe pain, which localized anteriorly to a newly developed tender bulging mass. The pain was worse at night, especially when she slept on the shoulder, and would occasionally radiate down the outer aspect of the arm.

She denied a history of local trauma or unusual stress. Her right wrist had been fractured two years earlier, but healed without residual symptoms. She had no other joint complaints. Further past history and systems review were noncontributory.

On examination, a tender, compressible ill-defined swelling was present anterior to the coracoid process on the right. No heat or redness were noted. The short and long heads of the biceps were tender, and Yergasons sign (reistance against flexion and supination of the forearm designed to stress the biceps) was positive for tenderness localized to the mass. Active range of motion was less than passive range of motion in all directions, and both were limited by pain. Palpation of the deltoid, acromion, supraspinatous, infraspinatous and lateral pectoral areas revealed no tenderness. There were no axillary nodes. Other joints were normal to examination.

### Laboratory

Sedimentation rate was 10 mm/hr. Rheumatoid factor was negative. SMA 18 and complete blood count were normal. X-ray of the right shoulder is shown in Figure 1. X-ray of the right wrist was normal.

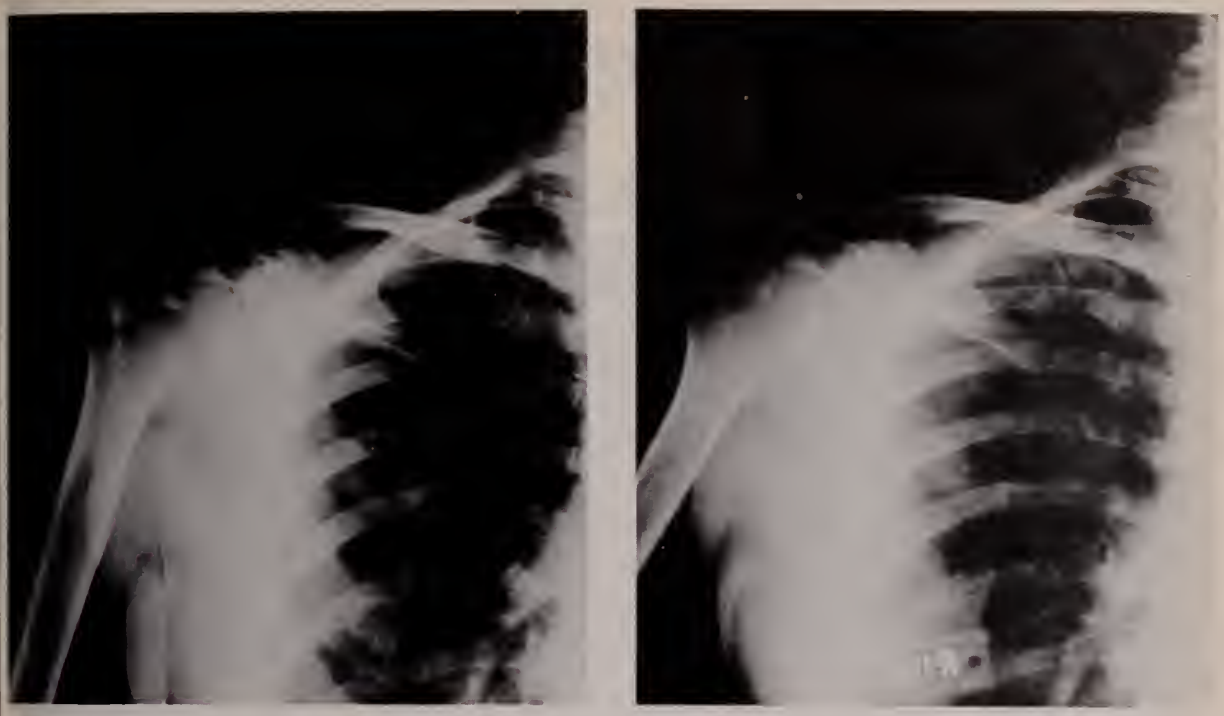
### Comment

Calcium deposits in tendons, ligaments and joint capsules are a frequent asymptomatic radiologic finding. Acute episodes of bursitis and tendonitis, and rarely, synovitis, are associated with such calcific deposits. Such deposits have been shown to be in the form of calcium hydroxy apatite crystals.[1] Deposits near the rotation cuff of the shoulder are those best known to clinicians. These occur in 3% of an unselected population.[2] They frequently give acute episodes of subacromial or subdeltoid bursitis with pain on abduction and tenderness under the acromial tip. Deposits are also commonly seen in other shoulder tendons,[3] and near the greater trachanters of the hip.[4] Smaller calcifications have been infrequently seen in tendons and ligaments near the wrist, elbow, knees, ankles and the interphalangeal joints of the hands and feet, where they may also cause inflammation.[4]

Attacks are heralded by pain and tenderness near the site of the calcific deposit, where a bursa may form. The reason why a dormant deposit suddenly causes onset of acute inflammation is not known. Apatite crystals, like urates, cause inflammation when injected into soft tissues, but may lie inert in some tissues for a time. Clinically the attacks may be acute and gout-like in nature[5] or more local and chronic as in a "tennis elbow." A localized area of tenderness near the calcium is usually found, but pain on motion of the neighboring joint simulating intra-articular disease is frequent.

It is not known whether tendon degeneration precedes the deposits or vice versa. No metabolic or hormonal abnormalities have been demonstrated. Some patients have involvement of multiple sites and recurrent attacks suggesting some underlying systemic abnormality.[6] Deposits have been found to cause gout-like attacks in patients on dialysis for chronic renal failure.[7] This suggests a metabolic abnormality.

Oral anti-inflammatory agents may be tried but are generally ineffective. Aspiration of the bursa, if well defined, may result in calcium crystal removal and subsequent relief. Injection



A B

**Figure 1**
**The dense calcific deposit can be seen moving medically as the arm moves from external rotation (A), to internal rotation (B), placing the mass anterior.**

of a lidocaine and steroid combination into the areas of tenderness usually results in prompt relief of symptoms and may be curative. Healing is often associated with spontaneous reabsorption of the calcium. Deposits may recur, and surgical removal may be necessary. Colchicine has been effective in the inflammation associated with chronic renal failure.[7]

## Conclusion

Calcium deposit on X-ray lead to a diagnosis of calcific tendonitis in an unusual position, probably the short head of the biceps. The biceps tendonitis and anterior bursitis were thought secondary to apatite induced soft tissue inflammation near the coracoid where the short head of biceps inserts. A 22-gauge needle was placed into the ill-defined mass and 2 ml. of fluid containing chalky-white granules were removed. A lidocaine and steroid solution was injected into the area and brought rapid pain relief. Normal range of motion was restored, which demonstrated an absence of underlying adhesive capsulitis (frozen shoulder) which sometimes accompanies such lesions. The patient had only minimal pain the next day, and on six month follow-up was entirely asymptomatic. ◄

## References

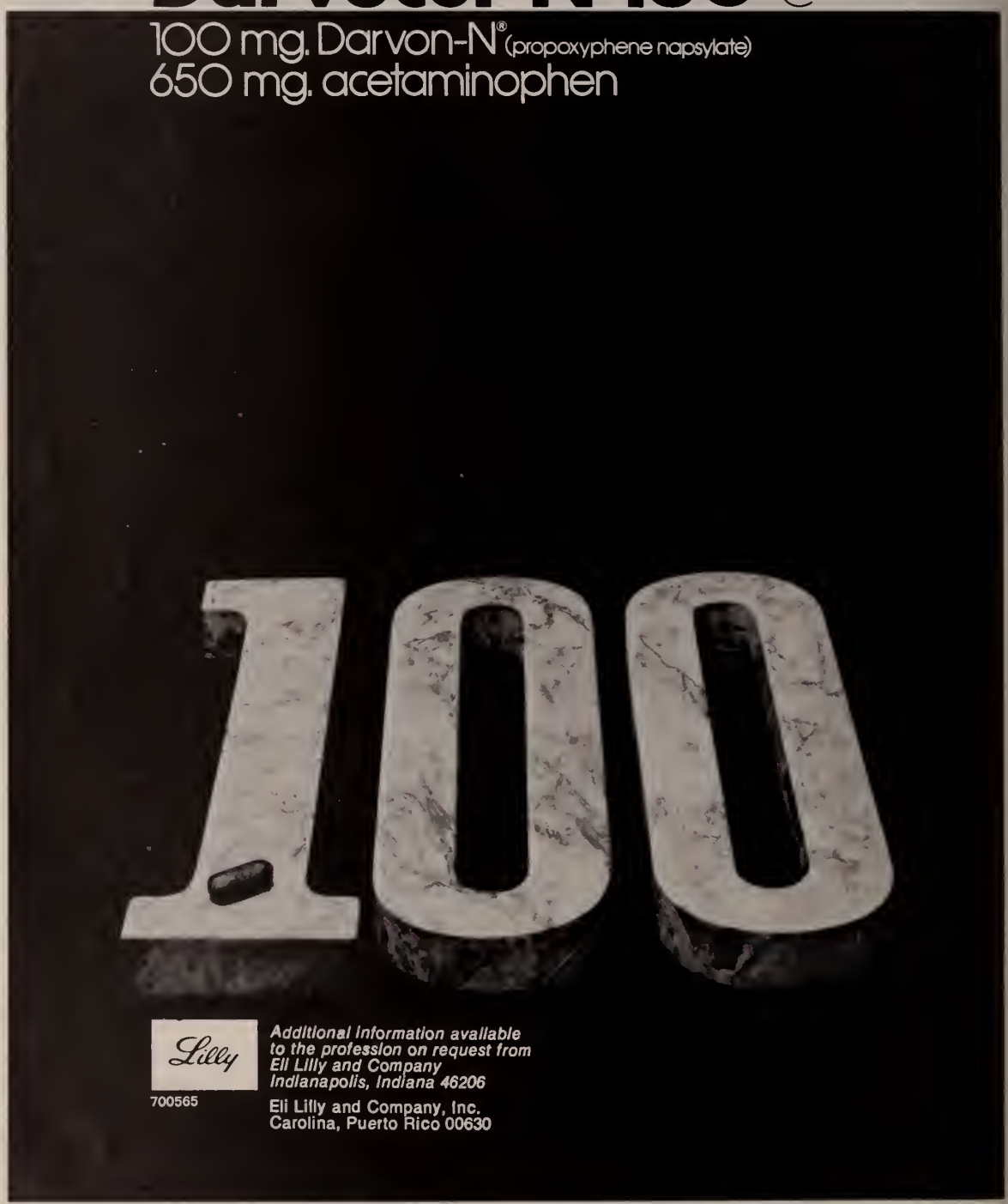

1. McCarty, D. J. and Gatter, R. A.: "Recurrent Acute Inflammation Associated with Focal Apatite Crystal Deposition," *Arth. and Rheum.*, 9:804-819, 1966.
2. Bosworth, B. M.: "Calcium Deposits in the Shoulder and Subacromial Deposits," *JAMA*, 116:2477-2482, 1941.
3. Goldenbert, R. R. and Leventhal, G. S.: "Supratrochanteric Calcification," *J. Bone Joint Surg.*, 18:205-211, 1936.
4. Key, J. A.: "Calcium Deposits in the Vicinity of the Shoulder and Other Joints," *Annals of Surgery*, 129: 737-755, 1949.
5. Thompson, G. R., Ting, Y. M., Riggs, G. A., *et al.*: "Calcific Tendonitis and Soft Tissue Calcification Resembling Gout," *JAMA*, 203:122-130, 1968.
6. Pinals, R. S. and Short, C. L.: "Calcific Periarthritis Involving Multiple Sites," *Arth. and Rheum.*, 9:566-574, 1966.
7. Moskowitz, R. W., Vertes, V., Schwartz, A., *et al.*: "Crystal Induced Inflammation Associated with Chronic Renal Failure Treated with Periodic Hemodialysis," *Am. J. Med.*, 47:450-460, 1969.

# contains no aspirin

tablets

## Darvocet-N® 100 ⓘⓥ

100 mg. Darvon-N® (propoxyphene napsylate)
650 mg. acetaminophen




Lilly

*Additional information available to the profession on request from Eli Lilly and Company Indianapolis, Indiana 46206*

700565

Eli Lilly and Company, Inc.
Carolina, Puerto Rico 00630

IMJ
Illinois Medical Journal
Vol. 154, No. 1, July, 1978

# Rape: A Community Hospital Study

Pedro A. Poma, M.D. and Robert C. Stepto, M.D., Ph.D./Chicago

*Rape is a violent crime that has increased in incidence (Federal Bureau of Investigation—1975). Illinois Law (PA 79-564, effective January 1, 1976) mandated the Illinois Department of Public Health to prescribe minimum standards, rules and regulations for emergency care of alleged rape victims in Illinois.*

*Before the law became effective, private practitioners were not usually aware of the circumstances of rape and the requirements of rape victim management.*

The records of women admitted for treatment to the Emergency Room (ER) at Mount Sinai Hospital Medical Center of Chicago between January 1, 1974 and December 31, 1975, have been studied carefully. Multiple variables were noted and constitute the basis for this report. The hospital is located in Chicago's inner city.

During the study period, when an alleged rape victim presented in the ER, the ER nurse would guide her into a private room. Here the surgical resident evaluated her specifically for life-threatening conditions and extragenital injuries. The gynecological resident would then take a history and perform sexological examination, evidence collection, prophylaxis and therapy when indicated. The nurse remained in the room throughout the procedure. Other tests and specialty consultations were done when necessary.

## Results

During the study period, 236 women were attended in the ER for the complaint of rape. The incidence of reported rape was higher during the summer months (mean 26) when compared to other months (mean 17). Age of alleged rape victims ranged from three to 47 years. Forty-five (19%) were younger than 16 and only two were older than 45; 114 women had never been pregnant.

PEDRO A. POMA, M.D., is on ossistont professor of obstetrics and gynecalogy affilioted with Rush Medical College in Chicago. Doctor Poma is vice-choirman of the deportment of obstetrics and gynecology ot Mount Sinai Hospital and Medicol Center. He is a consultont in gynecology at the Loyola University Sexual Dysfunction Clinic ond former director of the obstetrics and gynecology clinics for Cook County Hospital.



ROBERT C. STEPTO, M.D., is o professor of obstetrics and gynecology at Rush Medical College and the chairman of the department of obstetrics ond gynecology at Mount Sinai Hospital ond Medicol Center. Doctor Stepto has received certificates of recagnition from the University of Chicogo Alumnoi Association ond HEW, and lists his most active interests in the field of gynecologic oncology ond endocrinology.

### Time and Place

Rape allegedly occurs more commonly during the dark hours. In this study, 66 incidents were reported during daylight hours (6 a.m.-6 p.m.). Fifty per cent of all cases occurred in the street; 27% in the victim's home and 23% in a car.

### Number of Attackers

According to the alleged victims, 29.6% (70) of the incidents were associated with multiple attackers, usually two (in 41 cases), but there was one case where 15 persons abused the victim. Of the cases studied, 166 reported a single attacker and nine reported multiple attacks. The attacks were vaginal only in 204 cases; there were nine oral or rectal intercourse attacks. In one case contact was only oral and 22 victims reported no penile insertion; ejaculation occurred at perineum. There were eight cases of incest and 54 of the victims knew their attackers.

### Method

The method used by the attacker was recorded in 107 of the cases studied. In 43 cases there was either verbal threat to harm others (seven), or physical harm to the victim (36). In eight cases drugs and alcohol were used. Weapons were used in 56 cases (38 instances: guns; 13 instances: knives; two instances: candle holders and in three instances: bricks).

There were reports of seven cases in which either a girlfriend or boyfriend took the victim to the attackers. A rear-end collision was used to start contact with the victim in one case. In three cases the victim returned home to find a burglar; 15 victims told us that they were robbed following attack.

### Interval

The interval between the alleged attack and arrival in ER ranged from 14 minutes to 65 hours. In 68 cases this information was not available. In 147 cases, the interval was shorter than five hours; in four cases longer than 24 hours. Eighty-eight percent of the women in this study were single; 159 alleged victims were accompanied to the ER by a female (usually the victim's mother) and 64 by a male (usually the victim's husband). Only 13 victims came for treatment alone.

### Pregnancy Risk

At the time of attack 22 victims were premenarchal and 171 were at different phases of their menstrual cycle (18 were menstruating; 62 in the first half of their cycle, 10 at midcycle, 81 in the second half of the cycle). Pregnancy was diagnosed in 19 cases (14 at three months or less, one in the second trimester, and four in the third trimester). Six victims were in the postpartum period, three were postmenopausal and 15 had hysterectomy before the incident. Therefor, 176 victims were at risk of pregnancy. Of these women, 75.30% (128) were not using contraceptive measures when attacked; seven had been sterilized, and 35 were employing temporary methods of contraception.

### Injuries Resulting from Attack

There was no evidence of physical injury in 136 cases; 42.37% suffered injuries (121 extragenital injuries and 49 genital injuries). In some cases more than one type of injury was sustained. Abrasions were more common than lacerations and hematomas.

### Extragenital Injuries

Abrasions were more common on the upper and lower extremities, face and back. Hematomas were most often incurred in the face. Lacerations were present at the head, face, extremities and neck.

### Genital Injuries

Abrasions were common in the vagina and vulva. Hematomas were seen usually in the vulva and lacerations were noted at the vulva, vagina and perineum. There were 25 cases where the hymen was described as intact; one of these women was pregnant, two others presented with the tail of an IUD evident.

### Other

Severe psychological reaction was exhibited by nine victims, characterized especially by over stimulation and aggression. In five cases there was history of lost consciousness.

Severe injuries required hospitalization for three patients; one of these victims required blood transfusions. Alcohol intake was obvious in five cases and drug usage was admitted or suspected in three. According to relatives, two of the alleged victims had previous psychiatric treat-

ment. Mental retardation was evident in two cases.

### Semen Studies

There was no information of semen evaluation in 121 records. Pelvic examination was not done (either because the alleged victim refused it or because of the young age of the victim) in 32 cases. Records for 83 illustrated the presence of semen—in 65 it was motile and in 18 semen was non-motile. Specimens were taken from the posterior vaginal fornix.

### Venereal Disease Prophylaxis

There was no documentation of any therapy in seven records. Penicillin was used intramuscularly in 205 cases, tetracycline in 12, spectomycin in eight, erythromycin in four. There were five recorded instances of previous allergy to penicillin.

### Pregnancy Prevention

There were 101 cases not at risk and one patient who refused prophylaxis against pregnancy. Seven had just menstruated and considered at no risk. Of the 127 patients who agreed to medication, 96 received ethylbestrol orally, 20 had progestins orally and 11 intramuscularly. There was no evidence of pregnancy in this group, but the follow-up has not been satisfactory.

### ER Admission—Discharge Interval

This information was not available in 50 records. Three women were admitted to the hospital. In 137 cases the interval was less than two hours. In 42 cases the interval was up to four hours. During this period of time X-ray studies were done in 21 cases and superficial laceration suturing in 13 cases. Medical consultation was required in three cases (i.e. glucosuria) and psychiatric consultation was necessary in four cases.

### Discussion

Rape is one of the least reported violent crimes, probably because social pressures and upbringing place the victim (usually female) in a very difficult situation and holds her responsible for the incident. This is exacerbated when, as in most instances, she is the only witness or may have previously met the assailant, or dated him. Due to social stigma attached to this crime, rape is almost never reported in more affluent communities. We hope women who do not report assault are aware of the consequences and obtain appropriate care and counselling.

Rape can happen to anyone, at any age or place, but the recorded incidence is usually higher during reproductive years. In this study only 19% were younger than 16 years. Massey[1] reported 24%, Hayman and Lanza[2] 36%. The assault occurs commonly in the victim's home, and very rarely at a friend's home. In the latter situation the victim may have more difficulty in establishing her claim.

The approach or techniques used by the attacked or attackers are multiple, according to Burgess and Holstrom,[3] and on some occasions a known or trusted person escorted the victim to the attackers. In other cases rape followed another intended crime, e.g., burglary. Often enough the rape is committed by more than one aggressor. Women in this study were aware of the need for medical services; most of them came to our ER within five hours. This is the ideal time for detecting motile sperm and to initiate other therapy or prophylaxis. Others were held by their assailant and/or were not aware of the services provided.

The authors stress the individual's right to seek and receive these services and treatment even if the "victim's decision" is not to report the incident to the authorities.

The evaluation of menstrual status and contraceptive measures in our study group revealed a need for prophylaxis in relation to unwanted pregnancy, even when the risk is small. Most of these patients agreed to medication to temporarily change the condition of their endometrium and prevent nidation, and also penicillin for VD prophylaxis. Injuries noted were 71% extragenital, 29% genital. Extragenital injuries were more common, Burgess and Holstrom[3] reported 60%, Robinson 29%[4] and Massey 10.6%.[1] Genital injuries were 39%, 8.5%, and 5.2% in those series, respectively.

Rape is not a medical diagnosis. The court decides if rape occurred. The presence of semen is not legally required to establish rape. Members of the health team have responsibility to provide evidence. The ability to collect this type of evidence must be reinforced because it is not usually taught. The collected specimens must be properly identified and handled according to a very rigid protocol if they are going to have any value in court. The presence of semen can establish the fact that intercourse happened sometime before examination. The problem remains for

the courts to decide if this occurred voluntarily. G. F. Sensabaugh[5] reported that gelelectrophoresis evaluation of seminal enzymes may facilitate individual identification with 95% probability. Under the present court system, the alleged assailant may refuse the testing.

We consider the treatment provided at our institution efficient and expedient, with medical and psychological needs attended. The prophylaxis for venereal disease appears satisfactory, but the severe secondary effects of commonly used medications to alter the condition of the endometrium to prevent nidation do not. The use of intramuscularly administered progestrin or parental estrogens may be more appropriate, but there is still the possibility of secondary effects in a few cases and patients should be made aware of the reported association with congenital malformations.

The victims advocacy program appears the most important step into complete victim management. The feminist movement, the establishment of "sex squads"—vounteer citizen groups providing protection, counselling and 'hot lines' —and increased societal awareness have all improved the handling and reporting of this crime.

Regular meetings of concerned health team members involved in the counselling and management of rape victims may further improve their standard of care. There has been such a program initiated in this institution. Complete eradication will require successful treatment centers for the aggressors, and societal attitudinal changes in relation to sexual attitudes and stereotyped roles.

Sex is something one does *with* another person, not *to* another person. Rape is a violent crime; an aggressive act that violates the rights of another person. ◄

**References**


1. Massey, J. B., Garcia, C. R., Emich, J. R.: "Management of Sexually Assaulted Females," *Obstetrics & Gynecology*, 38, No. 1:29-36, 1971.
2. Hayman, C. R., and Lanza, C.: "Sexual Assault on Women and Girls," *Am. J. Ob. Gyn.*, 109, No. 3:480-86, 1971.
3. Burgess, A. W., and Holstrom, L. L.: RAPE: VICTIMS OF A CRISIS, Robert J. Brady Co., pub., Maryland, 1974.
4. Robinson, H., Sherrod, D. B. and MacCarney, C. M.: "Review of Child Molestation and Alleged Rape Cases," *Am. J. Ob. Gyn.*, 110, No. 3:405-6, 1971.
5. Sensabaugh, G. F.: *Conference on Chemistry and Spectroscopy*, Los Angeles, California, 1975.



# Army Medicine wants more doctors who specialize.

If you're a physician specializing in pediatrics, anesthesiology, radiology, or internal medicine, we've got a full range of career opportunities for you.

These opportunities are available in a setting that's about as free from non-medical distractions as it's possible for a practice to be. If you're a doctor who's more interested in practicing medicine than the running of a practice, Army Medicine could be perfect for you. Just call your local Army Medical Counselor, and he will discuss specific assignment opportunities with you.

Counselor/Phone Number

Captain Alex Fedorov 312-926-2147

or

Captain George Warneck 314-268-3846

**Army Medicine. The practice that's practically all medicine.**

## A New Approach

# Bedside Barium Enema

By Samuel C. Balderman, M.D., Krishnan Sriram, M.D. and
Arthur G. Michel, M.D./Chicago

*The general surgeon is often confronted with a patient who has massive lower gastrointestinal bleeding and presents diagnostic and therapeutic problems. The typical patient is an elderly individual who is brought to the emergency room by his relatives, or is transferred from a nursing home. He or she may be in poor physical condition with low blood pressure and thready pulse. After preliminary resuscitative measures in the ER the patient is transferred to the intensive care unit while preparations are made for diagnostic studies such as barium enema or an angiogram. A proctoscopy is, of course, done first.*

*In many instances the patient's poor general condition precludes transport to the radiology department for diagnostic studies. We suggest in this communication the use of barium enema at the bedside. The procedure is simple to perform and is often diagnostic and therapeutic.*

A catheter with a 30cc balloon is introduced into the rectum and the bulb inflated with normal saline or air. About 1500 to 2000cc of the barium solution is slowly introduced and the patient closely observed for any discomfort. Caution must be exercised to avoid perforation of the bowel. The patient is sequentially rotated from a left lateral to supine and right lateral positions. The plastic bag with barium solution is kept at a height of four feet from the bed. A scout film of the abdomen is taken with catheter still in place.

The barium solution is empirically left in the colon for 60 minutes. Then the plastic bag is placed on the floor to facilitate re-collection of the solution. The balloon is deflated and catheter removed.

A post-evacuation film may also be obtained.

### Case One

A 79-year-old white male was admitted to the hospital with a 24-hour history of lower gastrointestinal bleeding. It was his first episode of this nature.

The patient had a history of atrial fibrillation and left cerebrovascular accident some months before admission. The condition had since partially resolved and he was on digoxin and quinidine.

Physical examination revealed a frail, elderly individual with a pulse of 120/minute and BP of 90/60 mmHg. There was tenderness without rebound in the left lower quadrant. Rectal examination revealed fresh blood and blood clots but no mass. A naso-gastric tube was inserted; the aspirate was clear. The patient was initially managed in the ward. However, massive rectal bleeding continued and the hematocrit remained at 25% despite rapid blood transfusion. The patient was transferred to the intensive care unit at which time he continued to be tachycardic with a systolic BP of 60 mmHg. His hemoglobin was 7.6 Gms% and hematocrit 24%. EKG was



SAMUEL C. BALDERMAN, M.D., is a cardiothoracic surgeon affilioted with the Loyola University Stritch School of Medicine. He is o board certified general surgeon, ond o fellow in cordiac surgery.



KRISHNAN SRIRAM, M.D., is a clinicol instructor in surgery at the University af Health Sciences/Chicago Medical School. He is affilioted with the Veterons Administration Haspital in north Chicago.

ARTHUR G. MICHEL, M.D., is a general surgeon and directar of Surgicol Intensive Core ot Michael Reese Haspitol ond Medical Center in Chicogo. Doctor Michel is olso o fellow of the Americon College of Surgeons.



**Figure 1**

**Photograph of bedside barium enema showing multiple diverticuli in the descending and sigmoid portions of colon.**

read as "acute coronary insufficiency."

Proctoscopy was difficult and inconclusive because of excessive bleeding. Angiography was deferred because the patient was elderly, in shock and obviously had severe atherosclerosis (previous history of cerebrovascular accident).

Barium enema was administered at the bedside and the roentgenogram showed multiple diverticuli in the descending and sigmoid portions of the colon (see Figure 1). The bleeding stopped soon after administration of the barium solution. The patient had received 5 units of blood.

He continued to improve. There was no recurrence of bleeding. He was discharged without elective surgery.

### Case Two

A 66-year-old black male, a known alcoholic with a previous history of myocardial infarction, was admitted to the intensive care unit with a two-day history of passing bloody stools. The stools were described as containing both bright red blood and maroon-colored clots. His past history was unremarkable except for appendectomy in childhood.

Upon admission his blood pressure was 90/60 mmHg and pulse 140/minute. Hemoglobin was 14.4 Gms% and hematocrit 43%. Prothrombin and partial thromboplastin times were within normal limits. The gastric aspirate was clear.

Gastroscopy done the next morning revealed a duodenal ulcer at the apex of the duodenal bulb. The ulcer was not actively bleeding and there were no varices. The nasogastric tube was not re-inserted after gastroscopy. The patient was started on oral milk and Maalox®.

Proctoscopy at bedside showed fresh blood and maroon-colored clots in the rectum but was otherwise negative. Bedside barium enema showed no mass lesions or diverticuli.

Bleeding per rectum continued on the second day after admission. Hemoglobin fell to 8•5 Gms%. A total of 10 units of blood were administered over a period of 16 hours. Pulse rate persisted at 120/minute. It was decided that surgery was necessary. At surgery, a bleeding duodenal ulcer was found. Partial gastrectomy with Billroth II anastomisis and vagotomy was done. The post-operative course was uneventful.

### Discussion

Localization of bleeding within the gastrointestinal tract can be very taxing. While proctoscopy and barium enema are useful in the localization of a lower GI bleed, angiography is most accurate.[1] Nusbaum and associates (1969) have clearly demonstrated the safety and usefulness of percutaneous retrograde angiography in localizing bleeding of as little as 0.5 ml/minute.[2] However, in an elderly patient with multiple medical problems, especially atherosclerosis, angiography may be contraindicated. The success rate in such patients is also poor.[3] In such an event, barium enema is a useful alternate diagnostic measure. Needless to say, if angiography should follow barium enema the retained barium makes the radiologist's task very difficult. The latter should therefore be done only after deciding not to perform an angiogram.

While the most common cause of all rectal bleeding is carcinoma, massive rectal bleeding is most often due to diverticulosis.[4] Fortunately, compared to other lesions like polyps, diverticulosis is easily demonstrated radiographically. Barium enema will not usually identify the site

of bleeding but the presence of diverticulosis influences subsequent patient management.

Barium enema can be therapeutic, as illustrated by Case One. Adams (1970) reported cessation of massive rectal bleeding after the use of barium enema in 26 out of 28 episodes in 22 patients.[5] While there is no clear explanation for this effect, two factors may be considered, namely, pressure by the barium solution producing tamponade and a direct hemostatic action by the barium sulfate. The former seems more probable, as the effect is often immediate. It has been calculated that an intraluminal pressure of about 90 mmHg is produced when barium enema is administered.[6] As hydrostatic pressure is the most likely reason for the therapeutic effect of barium enema, it seems justifiable to use saline instead of barium solution if angiography is contemplated.[7]

Once rectal bleeding is controlled the patient can undergo a thorough gastrointestinal work-up with no urgency. Elective surgery was not done on Case One because of his poor general condition, though others believe that it should be done.[8,9] However, if the patient continues to bleed, emergency laparotomy must be performed without undue delay.

The technique of bedside barium enema helped considerably in the management of these two patients. In the first patient, diverticulosis was revealed and the procedure stopped the bleeding. In the second patient, a diagnostic problem, the presence of a lower gastrointestinal lesion was ruled out with reasonable certainty.

To summarize, although ideally performed in the radiology department, barium enema can be easily and safely performed at bedside even in poor risk and unstable patients. It helps considerably in pre-operative evaluation and is therapeutic in many instances. It is our hope that bedside barium enema examination might be used more often. ◄

### References


1. Casarella, W. J., Kanter, I. E., and Seaman, W. B.: "Rightsided Colonic Diverticula as a Cause of Acute Rectal Hemorrhage, *N. Engl. J. Med.*, 286:450-453, 1972.
2. Nusbaum, M., Baum, S., and Blakemore, W. S.: "Clinical Experience with the Diagnosis and Management of Gastrointestinal Hemorrhage by Selective Mesenteric Catheterization," *Ann. Surg.* 170:506-514, 1969.
3. Drapanas, T., Pennington, D. G., Kappleman, M., and Lindsey, E. S.: "Emergency Subtotal Colectomy," *Ann. Surg.*, 177:519-526, 1973.
4. Noer, R. J., Hamilton, J. E., Williams, D. J., and Broughton, D. S.: "Rectal Hemorrhage: Moderate and Severe," *Ann. Surg.*, 155:794-805, 1969.
5. Adams, J. T.: "Therapeutic Barium Enema for Massive Diverticular Bleeding," *Arch. Surg.*, 101:457-460, 1970.
6. Noveroske, R. J.: "Intracolonic Pressures During Barium Enema Examination," *Amer. J. Roentgen.*, 91:852-863, 1964.
7. Eisenberg, H., Laufer, I., and Skillman, J. J.: "Arteriographic Diagnosis and Management of Suspected Colonic Diverticular Hemorrhage," *Gastroenterology*, 64:1091-1100, 1973.
8. Asch, M. J., and Markowitz, A. M.: "Diverticulitis Coli: A Surgical Appraisal," *Surgery*, 62:239-247, 1967.
9. Ulin, A. W., Sokolic, I. H., and Thompson, C.: "Massive Hemorrhage from Diverticulitis of the Colon," *Ann. Int. Med.*, 50:1395-1406, 1959.



## PHYSICIAN
## Assistant Medical Director

Blue Cross/Blue Shield, an established leader in the health insurance industry, seeks an Illinois licensed Physician to assume a broad scope of medical administrative responsibilities. 4-5 years active medical practice background that includes hospital experience and one year experience in administrative medicine represent minimal professional requirements.

Incumbent will be "on call" for medical emergencies and have full charge responsibility for the Employee Health Clinic (budgeting, staff supervision, program planning, etc.). Additional involvement will encompass:

- *Review of Major Claims*
- *Research and Update of Drug, Procedural, Testing and Medical Policy Information*
- *Divisional Communications, Organization and Policymaking*
- *Orientation of Hospital Staff Physicians*
- *Review of Medicare Regulations*

For confidential consideration forward letter or resume to Clifford Lord.

**BLUE CROSS/BLUE SHIELD**
233 North Michigan Avenue
Chicago, Illinois 60601
*Equal Opportunity Employer M/F*

# Pediatric Perplexities

Ruth Andrea Seeler, M.D., Contributing Editor

*The Pediatric Perplexities series analyzes slightly uncommon pediatric disorders which require prompt diagnosis and specific management modalities. The editor welcomes suggested topics and questions from interested readers.*

# Organophosphate Poisoning

By Iqbal A. Memon, M.D./Chicago

*Accidental ingestion of poisons is a major pediatric problem and cause for hospitalization. The vast majority of toxic ingestions can be managed only with general supportive measures for there are often no specific antidotes. The pediatrician must know those potentially lethal compounds for which a specific antidote exists and can be life saving. Ingestion or contact with organophosphorous materials can be rapidly fatal, and produces a specific group of signs and symptoms that when recognized clinically allow for accurate diagnosis and immediate institution of appropriate antidotal therapy.*[1,2]

A 14½ month old black male was brought to the emergency room of Cook County Hospital by his mother approximately five hours after he had ingested an "ant killer." The solution, contained in a soda pop bottle in the bathroom, had been borrowed from a neighbor's large container. The child simply picked up the bottle and ingested an unknown quantity. Approximately 30 minutes later the child vomited and his mother gave him some milk. Three hours after ingestion it was noted that the child had noisy and rapid respirations. He became lethargic and was brought to the emergency room.

Physical examination revealed a comatose child with copious secretions from the pharynx, mouth, and nose. He was not responding to painful stimuli and the pupils were markedly miotic. Blood pressure was 114/42 mmHg, pulse 160/min regular, and respiratory rate 50/min. The patient was flaccid with an occasional fisciculation of voluntary muscles. The deep tendon reflexes were absent. Coarse rales were heard throughout both lung fields.

The diagnosis of organophosphorous poisoning was suspected and the child was admitted to the pediatric intensive care unit. Intravenous fluids were started, he was given oxygen, suctioned and placed on continuous EKG monitoring. Intravenous atropine 0.05 mg/kg was repeated every 15 minutes for a total of 5 doses until the clinical signs of atropinization, fever, urinary retention, and dilated pupils were evident. An additional three doses of the atropine sulfate had to be given at approximately six hour intervals. The indications for subsequent atropine administration were the reappearance of miosis and decrease in alertness. Pralidoxime in a dose of 20 mg/kg was administered intravenously along with the third dose of atropine and with the sixth dose of atropine (six hours after admission). The child showed progressive improvement in the level of consciousness and increase in motor tone. The first effects of therapy were noticed following the third dose of atropine and the first dose of Pralidoxime. This

IQBAL A. MEMON, M.D., is a resident in the department of pediatrics of Cook County Hospital in Chicago.

therapy was continued as the patient began to do well and vital signs remained stable.

Blood for toxicological analysis confirmed organophosphorous compound ingestion by the determination of the cholinesterase level of 15 Rappaport units, the normal being greater than 50 units. This was subsequently substantiated by the mother who was able to locate the original container. It listed an organophosphorous compound.

**Second Case Report**

A 21-month-old black male was brought to emergency room of another hospital after drinking an unknown "roach spray." The "roach spray" had been borrowed from a neighbor and placed in a bottle which was left near the bathtub. The child picked up the bottle and ingested an unknown quantity. The original container had been discarded by the neighbor. Within 10-15 minutes the child began to gag and started to drool. Soon he became drowsy and was rushed to the nearest emergency room where he was found to be semi-comatose approximately 30-minutes after the ingestion. They noted copious secretions from the mouth and heard rales throughout the lung field. Gastric lavage was performed with normal saline, and intravenous fluids started prior to transfer to our hospital. Upon arrival 3½ hours after ingestion he was comatose, barely responded to painful stimuli, and had copious secretions from the mouth and nose. The child had three watery stools within ten minutes of arrival.

Physical examination revealed a blood pressure of 110/70 mmHg, the pupils were equal but pinpoint in size. Extremities were flaccid and voluntary muscles fisciculations were noted. The deep tendon reflexes were absent. The previously noted rales were heard throughout both lung fields.

The child was admitted to the pediatric intensive care unit where he was intubated and suctioned thoroughly. Continuous EKG monitoring was established. Atropine sulfate was administered intravenously and repeated at 15 minute intervals for three doses. Pralidoxime was also given with the subsequent atropine doses at three and six hours after admission. The patient was maintained on a respirator because the blood gas determinations showed anoxia and acidosis accompanying an irregular and inadequate respiratory effort. After institution of the atropine and Pralidoxime the muscle fisciculation stopped, muscle tone increased, and the level of consciousness improved. After six hours the child was extubated and thereafter maintained normal blood gas tensions without ventilator assistance.

Because of the admission for ingestion a routine whole blood lead level was done, which was 80 micrograms percent and he subsequently received a course of chelation therapy with calcium EDTA and dimercaprol (BAL).

**Discussion**

There are many varieties of alkyl-phosphate compounds which are highly toxic due to phosphyorylation which inhibits the enzyme acetylcholinesterase.[2] This leads to accumulation of acetyl-choline at the autonomic cholinergic nerve endings, both peripherally and centrally. The net result is continuous stimulation followed by inhibition. Organic phosphate compounds are readily absorbed through the intact skin, by inhalation through the lungs or absorption through the gastrointestinal tract. Doses as low as 0.1 mg/kg of parathione (a common insecticide on farms) have been lethal.[3] These compounds are used in the manufacture of a multitude of insecticide products which are widely used in homes and on farms.

The signs and symptoms of organophosphate poisoning occur within minutes or hours, but may be delayed up to 24 hours after exposure. The severity of the symptoms depends upon the amount of enzyme inhibition, which can be confirmed by an assay of serum cholinesterase activity. However, one does not need the laboratory diagnosis, in the presence of the signs and symptoms, to make the diagnosis and institute therapy. The signs and symptoms of organophosphorous poisoning are the results of effector sites stimulation of cholinergic centers. These include the central nervous system, somatic nerves, ganglionic synapses of the autonomic nerves, the para-sympathetic nerve endings, and sympathetic innervation of the sweat glands. The initial symptoms are due to over-stimulation which is followed by paralysis. Major signs and symptoms are summarized in Table 1.

For a successful outcome one must maintain good tissue oxygenation, which may require intubation and respiratory support in addition to frequent suctioning. One must avoid further exposure, and attempt to remove the organophosphorous by gastric lavage if it was ingested. The skin must be washed thoroughly if ex-

**Table 1***
**SIGNS AND SYMPTOMS OF ORGANOPHOSPHATE COMPOUND POISONING**

| | |
|---|---|
| EYE | Decrease in intraoccular pressure |
| Pupils | Miosis |
| Lacrimal glands | Increased secretion |
| Bronchial tree | Bronchoconstriction, dyspnea increased secretions, cough, cyanosis pulmonary edema |
| Cardiovascular system | Bradycardia, decreased cardiac out put, hypotension, blood vessel dilation except for pulmonary and coronary vessels |
| Gastro-intestinal System | Vomiting, cramps, watery and explosive diarrhea |
| Sweat glands<br>Salivary glands | Increased secretions |
| Urinary bladder | Frequent-voiding |
| Sympathetic ganglion | Tachycardia, elevated blood pressure |
| Skeletal system | Fasciculation, decreased muscle tone |
| Central nervous system | Restlessness, tremor, drowsiness, generalized weakness, coma, absent deep tendon reflexes, respiratory center depression |

*Modified from Namba, *et al.*[2]

posure occurred through cutaneous contact. Atropine sulfate is given intravenously in a dose of 0.05 mg/kg and should be repeated every 15 minutes, along with continuous electrocardiogram monitoring for arrythmias.[4] Atropine is required in exceedingly large doses in this ingestion as compared to the atropine requirement for usual clinical states. When atropinization is achieved (as indicated by dilation of the pupils, tachycardia, dry mouth, and hot flushed skin) the further doses of atropine are withheld until symptoms recur. It is important to correct any hypoxemia or acidosis, as their presence increases the risk of ventricular fibrillation secondary to the atropine therapy.

The specific antidote, pralidoxime, not only prevents but reverses phosphorylation of the acetyl-cholinesterase enzymes. This drug is used as an adjunct to atropine and is not a substitute. Pralidoxime is a quaternary amine and thus does not cross the blood brain barrier. For this reason, it is not thought to ameliorate the central nervous system effects of organic phosphorous compounds.[1,5-7] However, recent studies indicate the presence of a low concentration of pralidoxime in the central nervous system.[8] Clinical observations of prompt recovery from coma and control of convulsions in cases of organophosphorous poisoning following the use of pralidoxime provides some evidence against the earlier speculation that it did not enter the central nervous system.[9,10] The drug is usually administered intravenously in a dose of 10-12 mg/kg. Although it can be given intramuscularly, the absorption time may vary, which is why the preferable route of administration is intravenous. The dose may be repeated at one or two hour intervals or may be given by a continuous drip of 0.5 mg/hour until all symptoms are resolved. Side effects are very uncommon with the therapeutic dose. In unusually high doses, they are manifested by nausea, dizziness, diplopia, and impairment of accomodation. In the desperately ill child with organophosphorous poisoning these side effects are not a major drawback.

When managing a case of acute organophosphorous ingestion, it is important not to administer any other drugs which will potentiate the toxicity of the organophosphorous compounds, such as narcotics, phenothiazines, and theophyline derivatives.[11]

## Further Considerations

One must remember that symptoms may recur after the patient responds to atropine and pralidoxime. It is not unusual, as was observed in our patient, to require additional doses at 3-6 hours following initial response. These patients require close monitoring for an additional 24 hours after the last dose of atropine and pralidoxime. The toxicology laboratory can be invaluable for diagnostic confirmation. Organo-

phosphorous compounds may be detected in the gastric lavage, urine, or clothing. The primary blood test used to determine organophosphorous poisoning is the serum cholinesterase level. Remember the toxicology laboratory will be much more efficient in confirming the diagnosis if the signs and symptoms are listed on the laboratory requisition, or if they are aware that organophosphorous poisoning is suspected. The determination of cholinesterase levels in the serum and in the erythrocytes is the major confirmatory test. The cholinesterase levels within the erythrocytes are more accurate and are the preferred method, but they are technically more difficult and expensive to do. The serum levels are more simple and the results more readily available. A normal cholinesterase level excludes organophosphorous poisoning. The clinical signs and symptoms of organophosphorous poisoning do not occur until after 50% of the cholinesterase enzymes have been inactivated.[2] Levels in the 20%-50% range of normal would indicate mild poisoning; 10%-20% moderate, and less than 10% severe poisoning. Correlation is seen only early in the disease because during the recovery phase the cholinesterase levels rise rather slowly.

Nevertheless, the clinical signs and symptoms are so distinctive that the laboratory is merely a confirmatory test and not needed for clinical management.

### Final Remarks

In both our patients, the material was obtained from a neighbor or friend. Subsequent questioning determined that the insecticides had originally been packaged in large containers intended for use by exterminators in houses and apartments. Buying it in bulk provides a much cheaper source than the brand name products which are available in small household packages. In both cases, a friend or neighbor generously loaned the family some of their "left over" insecticides and these were placed in soda pop bottles and left in situations where children could easily pick them up. These patients dramatically point out that ingestion in children tragically occurs because the toxic substances that are placed in containers are designed to hold food and beverages. Part of modern pediatrics should include parental instruction on prevention of ingestion as part of routine health maintenance. Such discussions should include not only where to keep toxic substances and safety latches, but also the danger of unlabeled compounds in soda pop bottles. ◄

### References


1. Koelle, G. B.: Anticholinesterase Agents. Goodman, L. S., Gilman, A., Eds., MacMillan, New York, at 445, 1975.
2. Namba, T., Nolte, C. T., Jackrel, J., *et al.*: "Poisoning Due to Organophosphate Insecticides," *Am. J. Med.*, 50:475, 1971.
3. Gleason, M., Gosselin, R., Hodge, H.: Clinical Toxicology of Commercial Products. Parathion, at 183, Williams and Wilkins Co., Baltimore, 1969.
4. Hayes, W.: "Epidemiology and General Management of Poisoning by Pesticides," *Ped. Clin. N. Am.*, 17:629, 1970.
5. Ruthland, J. P.: "The Effect of Some Oximens in Sarin Poisoning," *Brit. J. Pharmacol.*, 13:399, 1958.
6. Hobbiger, F., and Sadler, P. W.: "Protection Against Lethal Organophosphate Poisoning by Quaternary Pyridine Aldoxime," *Brit. J. Pharmacol.*, 14:192, 1959.
7. Schaumann, W.: "Maximal Inhibition of Cholinesterase in the Central Nervous System," *Brit. J. Pharmacol.*, 15:432, 1960.
8. Firemark, H., Barlow, C. F., and Roth, L. J.: "The Penetration of 2-PAM into Brain and the Effect of Cholinesterase Inhibitors on its Transport," *J. Pharm. Exp. Therapeu.*, 145:252, 1964.
9. Namba, T., Hiraki, K.: "PAM (Pyridine-2-Aldoxime Methiodide) Therapy For Alkylphosphate Poisoning," *JAMA*, 166:1834, 1958.
10. Funckes, A. J.: "Treatment of Severe Parathion Poisoning with 2-Pyridine Aldoxine Methiodide (2-PAM)," *Arch. Environ. Hlth.*, (Chicago), 1:404, 1960.
11. Gains, T. B.: "Poisoning by Organophosphorous Pesticides Potentiated by Phenothiazine Derivatives," *Sci.*, 138:1260, 1962.


## *ISMS Travel Program*

Only one of the ISMS travel programs scheduled for 1978 remain open for reservations: the Eastern Mediterranean Air/Sea Cruise (Oct. 25-Nov. 7). Information on the 1979 programs will appear in the next issue.

Descriptive brochures will be mailed five months in advance. Reservations cannot be accepted without the official form printed in these brochures. Individuals outside a member's immediate family will be placed on standby status until all ISMS members have had reasonable time to make reservations. *Promotional expenses connected with these programs are paid for by the tour operator.* For further information, contact ISMS headquarters.




Edited By John M. Beal, M.D.

*Surgical Grand Rounds are held weekly on Tuesday at 5:00 p.m. in the Offield Auditorium of the Passavant Pavilion of Northwestern Memorial Hospital. Patient presentations from Northwestern Memorial Hospital and the Veterans Administration Lakeside Hospital form the basis of the discussions. This case report was part of the Surgical Grand Rounds of January 17, 1978.*

## Case Report

# Coronary Artery Surgery

**Dr. John Beal:** One of the most exciting recent medical developments has been the introduction of coronary artery surgery, but it has brought considerable controversy. A current series of publications has left uncertainty in the minds of many as to the real value of coronary artery bypass, an operation that is being done with increasing frequency. Doctor Michaelis has assembled a panel to discuss the merits of coronary artery bypass, the issues in the controversy, and to analyze the effectiveness of bypass surgery in coronary artery disease.

**Dr. Lawrence Michaelis:** Coronary artery bypass, in which a segment of saphenous vein is used to bypass obstructed coronary arteries, will be performed approximately 70 to 80 thousand times in the United States this year. The cost is, of course, staggering; however, the implications of the operation are also staggering. Before I discuss the surgical indications, I shall review the surgical anatomy of coronary arteries.

Normal coronary artery anatomy is variable. We usually talk about three major coronary arteries because the left main coronary artery bifurcates early. It provides a left anterior descending coronary artery and a circumflex coronary artery, which distribute vessels to the lateral border of the left ventricle. The right coronary artery is dominant in about 70% of the population. Dominance in the right coronary artery depends on the blood supply to the posterior interventricular septum. The posterior descending coronary artery, which in 70% of people is the terminal branch of the right coronary artery, supplies the back of the left ventricle. For all practical purposes, blood supply to the right ventricle is not very important; there is enough collateral in most people with normal pulmonary artery pressure so that complete occlusion of the right coronary artery can occur without much damage to the right ventricle. From the practical standpoint, we are considering the left ventricle

only. About 15% of the population has a dominant left coronary artery and their right coronary artery is not important in terms of the physiology of their ventricular contraction. An additional 15% or so of the population has a balanced circulation. When we talk about triple vessel disease, we refer to the left anterior descending coronary artery, the circumflex coronary artery and its branches and the posterior descending.

**Operative Indications**

When is the operation indicated? There are several things upon which even the most conservative cardiologists will agree. (1) The operation relieves pain by revascularizing ischemic myocardium. There have been a number of placebo operations or operations with questionable value. Suffice it to say the Vineberg operation (internal mammary artery ligation) and the Beck procedures (sclerosing of the epicardium) were said to relieve pain. They were very powerful placeboes, but were not nearly as effective as coronary artery bypass in relieving anginal pain. Probably somewhere between 90 and 95% of the people who have coronary artery bypass have either complete relief or great improvement in their angina. The high incidence of occluded grafts in people with persistent pain provides further evidence that the revascularization itself is the reason for the relief of their pain. Most people with recurrent angina have occluded grafts.

The surgery is also indicated for significant obstruction of the left main coronary artery. A number of studies have attempted to randomize patients. Significant obstruction of the left main coronary artery is the finding that ends the random nature of the analysis. Infarctions caused by obstruction of the left main coronary artery are very often fatal. Left main coronary obstruction accounts for only five to eight percent of coronary disease cases, but it is an important consideration and one that should be excluded from any consideration of medical management.

Thirdly, the operation is indicated in unstable angina with impending myocardial infarction. This is the most questionable category because, like cardiogenic shock, unstable angina must be defined. By definition, unstable angina is any change in previous stable angina. Certainly, when there is good indication that a myocardial infarction is imminent or that the angina pattern has changed to such an extent that medical management is not relieving it, almost all cardiologists concur that the operation is indicated.

**Contraindications**

When is the operation not called for? The operation is *not* indicated in two situations. The operation does not improve ventricular function. In other words, you cannot revascularize dead muscle. This does not mean that the operation was not indicated in the presence of left ventricular dysfunction, but it is not indicated *per se* for revascularization. It does not improve ventricular dysfunction caused by previously infarcted muscle. The operation is not indicated in the presence of diffuse small vessel disease. Adequate distal runoff is essential to perform bypass grafts.

There are two basic situations in which the operative indications are still uncertain. These are cardiogenic shock and whether the operation prolongs life.

Cardiogenic shock is, once again, also open to definition. There are people who have reported very good results in cardiogenic shock and others have reported dismal results. The few centers that are attacking cardiogenic shock vigorously with clear criteria have survival rates in the range of 20-30%, which is a very high mortality rate. They are operating under the assumption that their patients are going to have a much higher mortality rate without an operation. This is a major commitment for a medical center to take when studying cardiogenic shock.

The problems nationwide have been homogeneous criteria for cardiogenic shock and the timing of the operation. Statistically, it has not been proven that the operation is indicated. The overwhelming question, however, is whether or not coronary artery bypass grafting will prolong life. This seems like a very simple question.

The first problem is to find a prospective randomized study and a number of such studies have been proposed. We were involved in a 1972 study at the National Institutes of Health. Our results were typical.

The study was set up so the people were randomized after they had been studied. Those randomized to the operative groups said, "Thanks, great, go along with the operation." People who were randomized to the medical group said, "Thank you very much; I'm withdrawing from the study," and went someplace else to have an operation. We are not at the point where people

want the operation when they have angina and will not stay in the studies.

### Risk Considerations

Next, I want to discuss the risk consideration in coronary artery disease. What increases the surgical risk. First, obviously, is the extent of the coronary artery disease, as well as anatomical and technical considerations in performing the operation. These were more formidable four or five years ago than they are now, because the operative technique itself has improved. Next is left ventricular function. Obviously, if someone has a very good ventricle, he is going to tolerate the operation better than someone with very marginal left ventricular function. We assess left ventricular performance preoperatively by a number of means, ventriculography, ejection fractions, left ventricular end-diastolic pressure and presence or absence of congestive heart failure.

Associated heart disease is another factor. If someone has a ventricular aneurysm and mitral regurgitation, he is at higher risk. Consider the condition of the patient's angina—has it been stable, or has it been unstable? Recent myocardial infarction is another factor. There is evidence that the operation's risks increase tremendously if you operate within four to six weeks of a myocardial infarction. We make every effort to postpone surgery in people who have had a recent myocardial infarction.

Finally, the skill of the surgical team is important The team includes scrub nurses, pump technicians, operating room circulating nurses, house staff and surgical intensive care unit nurses. It has been very clearly shown that in centers where the whole team has cared for these patients on a regular basis, and the operation is done with frequency, better results are obtained than when the operation is done sporadically.

### Pertinent Research

An article from the New England Journal of Medicine based on a cooperative study with the VA has caused wide comment. In this VA study, 310 patients were in a medical group and 286 patients were in a surgical group. This was a prospective randomized study carried out in seven or eight VA centers throughout the United States. All patients agreed to stay in the study. All patients had angiographic evidence of significant obstruction of one or more coronary arteries. This was defined as a 50% reduction in lumen diameter, which is supposed to equal 75% reduction in cross sectional area of a vessel. Therefore, all had radiographic evidence of at least one obstructed coronary artery.

The VA study involved only chronic, stable angina. All of the standard surgical criteria were excluded. Excluded patients were those with any kind of myocardial infarction the last six months, any question of unstable angina, congestive heart failure in the last three weeks, any kind of associated heart disease, severe diabetes, hypertension in which the diastolic blood pressure was greater than 100 on therapy, and significant left ventricular dysfunction. The people in the study had good ventricles and chronic stable angina. The results three years after the operation were identical, in this VA study, for the surgical group and for the medical group. This is what has been presented in the newspapers.

But there are some considerations about the VA study that are very clear and are very important. The first real consideration is the number of grafts that were performed in these patients. This study is now three years old and showed an average of 1.9 bypasses per patient and no patient received more than three grafts. In most centers today, the average number of grafts performed is greater than 2.5 and it is not unusual to perform four or five bypass grafts in a patient in an effort for complete revascularization.

The next objection to the VA study is graft patency. In the VA study, 69% of all the grafts studied postoperatively were patent. Twelve percent of the patients had no patent grafts at all. Nineteen percent of the single bypass patients had occlusion of their grafts. Most centers reported over 85% in graft patency. As high as 88% has been recorded 6 to 12 months postoperatively and I would say 92 to 95% of patients should have at least one patent graft. The graft patency in the VA study is unacceptable by present cardiac surgical criteria.

The VA study reported an operative mortality of 5.6%. The surgical risk in this group of patients should have been 1 to 2% because patients with unstable angina, left main disease, recent myocardial infarctions and left ventricular dysfunction had been eliminated. By their criteria, in the last two years, we have not lost a patient in this hospital in people with chronic stable angina. Thus, a very high operative mortality rate was reported for this group of VA patients. Of course, that high mortality rate affected the

initial survival.

Another objection to the VA study is their statistical techniques. Seventeen percent of the original patient population selected for medical therapy experienced worsened symptoms and were transferred to the surgical group. If they died, they were considered surgical deaths, not medical deaths. These patients were considered lost to follow-up for the medical group.

In addition, the VA study failed to mention a large subgroup. The largest subgroup of the VA study were people with triple vessel disease and some left ventricular dysfunction. These patients were presented to the American Association of Thoracic Surgery in 1977. Survival of 85% in the surgical group and 76% in the medical group was reported at 54 months. This is considered statistically significant. The editorials made no mention of the finding that the triple by-pass patients with some left ventricular dysfunction had a statistically significant better chance after operation than they did after medical therapy.

With that background, Doctor Lesch will continue the discussion from a cardiologist's viewpoint.

**Dr. Michael Lesch:** The search for absolutes in the press and among ourselves has led to polarization, which I think has been counterproductive. There is to my knowledge no study in the medical literature which *proves* the value of penicillin therapy in pneumococcal pneumonia. It was so obvious and that was that. There is a lot invested in coronary surgery and I would like to go through some philosophical approaches. The data is the same. Rather than be a proponent or an opponent, I would like to look at this in a rational way and try to tell you as a practicing cardiologist what we do in a center where very good surgery is available.

The left main coronary disease issue should be put to rest. There is no question that surgery is the therapy of choice there.

The issue about the treatment of intractable pain has been met by the surgical/medical cardiologic community with the appropriate answers. Surgeons and cardiologists have shown that the operation is unequivocably the best available treatment for angina or is certainly a very adequate substitute for drug therapy which frees the patient of a number of constraints. It is society's duty to determine whether that's worth $15,000 per patient. That is, if in fact we're talking about the distribution of medical resources and the government does what they did in Canada. There they say essentially: "We have X million dollars of money for medicine. Doctors, you decide how you are going to spend it." Then the discussion departs from the medical point of view and becomes a socio-economic discussion.

I think there is no question that the operation is the most effective treatment of pain. The story of placeboes should be put to rest. In all of the previous operation, etc., the placebo effect usually lasted less than three months. In the studies that have been reported today on coronary patients, pain relief clearly lasts for more than three months—it lasts for years. The results are not due to placebo effect.

There are also people who say that their surgery is successful because it interrupts perivascular nerves. They conclude that any operation should be successful, whether it is successful grafting or not. This simply has not been proven. Probably the major objection is that approximately 50% of those patients reporting complete symptomatic relief, who have all grafts patent at recatheterization, have persistently positive exercise tests. Those who are familiar with any exercise testing know that there are about "25 pat reasons we will give for false positives." I simply interpret this as another reason for a false positive.

An interesting study at the recent American Heart Association meeting showed that examination of all exercise tests—isolating everybody with a positive test—uncovered 15 or 20% "false positives" insofar as ischemic heart disease was concerned. But if you look at the broader picture of heart disease, left ventricular hypertrophy due to hypertension, aortic valve disease, mitral valve disease, cardiomiography, myocarditis, etc., the false positive rate drops to zero. In other words, if you have a positive exercise test, the likelihood of not having heart disease is next to zero. The likelihood of having specific coronary disease is about 85%. When one considers the pericardities of operation, manipulation of the heart and the various operative effects, I'm not at all surprised at this positive test.

So, therefore, in terms of pain relief, it's clearly good. The question is: how do you define intractable? There are physicians who will not accept that a patient requires surgery or accept intractable pain until the man is literally dead. I find it somewhat difficult to deal with the absolute terminology of intractability. I would suggest that a number of variables have to be taken

into account. These include the patient's lifestyle, his age, his acceptance of surgery and his vascular anatomy.

For argument sake, consider a 49-year-old man with a perfectly good anatomical set-up for the operation. He might be a laborer or an executive who is under a lot of stress and simply finds it unreasonable to be gobbling pills, which I consider a perfectly acceptable reason for surgery. If on the other hand, he tells me, "It doesn't bother me, I will take one nitroglycerin every hour and I'm perfectly happy to do so," I have accomplished the same thing in terms of symptomatic relief. The number of pills is not a reasonable cut-off. You cannot say that a patient who takes more than 10 pills a day must have surgery; less than 10 pills, surgery is not indicated. I think the goal of medical therapy is to make the patient very comfortable, and we can frequently do that. If the means to that end requires an unacceptable, constant reliance on drugs, etc., then the patient is certainly a candidate for surgery. This is where the art of medicine comes in. It's no longer the science.

**Second Major Issue**

The prolongation of life issue is more difficult. The mortality rate for patients with coronary artery disease who have been treated medically has improved markedly in the past 15 years. Therefore, any study of surgical therapy must consider this change in medical treatment. While a new form of surgical therapy has been introduced, medical therapy has also become more effective in the aggressive treatment of arrhythmias and concepts of pre- and postcoronary care. Therefore, the medical therapy of patients with coronary disease is changing also.

Concerning the VA study, I agree that is was weak. In addition, the quality of the angiograms was poor. Some angiographers refused to review them. Coronary angiography in 1978 is far superior to what it was in 1971. Also, there is no question that surgical mortality is related to time and experience of the surgical team with the operation. We now have better techniques for protection of the left ventricle during surgery. For example, until three or four years ago, the preparation for surgery included withdrawal of propranolol because most cardiologists feared a decompensated ventricle at the time of surgery. Now we are not discontinuing propranolol and the rate of intraoperative myocardial infarction is decreasing.

**Some Support Samples**

There is a definite implication that coronary artery bypass is prolonging life. The examples that I give are the following:

A 39-year-old man with proximal vessel disease in all three vessels, almost complete obstruction lesions in the right, left anterior descending, and circumflex, with no collaterals. It is reasonable to suggest surgery for him. It is extremely likely that this man will have an infarction at some time in the next ten years. He is certainly no worse off with the operation and the grafts seem to be remaining patent for a considerable period of time.

Conversely, a 75-year-old man who has one proximal lesion, whose primary disease is distal and who has adequate collaterals, is not a candidate for operation.

I wish that I had some data to support our conviction about the management of patients who fall in groups between these two examples, but I am unaware of such information. From available information, the younger the patient, the more proximal the lesions, the less the involvement of the distal circulation, the fewer collaterals, the more I favor operating to prolong life. Data is not available to support this attitude and I don't believe we are going to get it. We are unable to establish studies that randomize people to having no therapy.

Another aspect of the VA study that should be said is that the quality of surgery was not good. Three or four hospitals contributed most of the mortality. Results of surgery at Hines and Stanford VA Hospitals were good. But when you have 25% of the hospitals responsible for 85% of the surgery and almost none of the mortality and then another 25% of the hospitals are responsible for less than 10% of the surgery, but 95% of the mortality in the total study group, it is difficult to accept the conclusions in such a study.

Medical therapy is not without its problems. Exercise mills are being created around the country for the treatment of coronary disease although there is no convincing data that exercise has any role in the secondary prevention of coronary disease. Nothing has ever been published that shows that exercising in a patient who has coronary disease will prevent or retard disease progression. However, if you question a hundred people in an exercise program after an infarct, they are quite convinced they are getting specific therapy. I find this just as reprehensible as by-

pass surgery for single vessel disease of the right coronary in patients who are asymptomatic.

We are in a quandry. The treatment of angina is not clearly defined. One has to take the best data that is available and then make a value judgment. When we recommend surgery, I tell patients that this is my best judgment. That's the best I can do.

**Dr. John Sanders:** I would like to show, for the purpose of comparison, results from other series. The first study is from Houston, Texas, where the quality over the years has been excellent. The Baylor College series follows a span of over 1,000 patients, all of whom have been followed beyond five years. It has the advantage of being a year or two years longer in follow-up than the VA study. Of these, there was a virtual equal mix of two and three vessel coronary disease. The balance of these are single vessel and greater than three vessel coronary disease. Their operative mortality from a group operated on in the early seventies was still 3.5%. Now, this would be somewhat improved. Their overall five-year survival was 90%, which was better than the shorter term follow-up of the VA group. Their five-year survival in patients who have good left ventricular function was even better—93%.

The patency rates in the Baylor College study were done at between six months and a year. There was an 87% overall patency rate, that is to say, 87% of all grafts performed were patent versus 69% of the VA series. That constitutes nearly a 20% difference in patency rate. Eighty-one percent had all grafts patent versus 54% in the VA group.

The follow-up from the Brigham series was just shy of six years. The results at that time showed that for single vessel bypass we expect 97.8% survival. It does exclude suicide, auto accidents, cancer deaths and deaths not related to coronary artery disease. From the coronary standpoint we can say that we have a 97.8% survival of single vessel disease for patients 5.5 years after operation. I think that even a good medical group would certainly not fare statistically significantly better than this.

Patients who have had coronary bypass surgery for three vessel disease anticipate a better than 90% survival rate at five and six years. The overall survival for all patients bypassed in this series, which comprises almost 600 patients, was better than 90% at six years. This was comparable to the Baylor series. We now consider the operative mortality for elective coronary surgery somewhere between 1 and 2%, which is quite acceptable for any major operative procedure. ◄

## References


1. Murphy, M. L., Hultgren, H. N., Detre, K., *et al.*: Treatment of Chronic Stable Angina: A Preliminary Report of Survival Data of the Randomized Veterans Administration Cooperative Study," *N. Eng. J. Med.*, 297:620-627, 1977.
2. Laurie, G. M., Morris, G. C., Jr., *et al.*: "Results of Coronary Bypass More Than 5 Years After Operation in 434 Patients," *Am. J. Cardiology*, 40:665-672, 1977.
3. Cohn, L. H., Collins, J. J., Jr.: "Improved Long-Term Survival Following Aorto-coronary Bypass for Advanced Coronary Artery Disease," *Am. J. Surg.*, 129: 380-385, 1975.



**COOK COUNTY**
**Graduate School of Medicine**

CONTINUING EDUCATION COURSES
STARTING DATES—1978

RADIATION SAFETY IN DIAG. RADIOLOGY, 3 days, July 24
SPECIALTY REVIEW MEDICINE, CERTIFYING, July 30 & August 6
STATE & NAT'L. BD. REV. BASIC, Augusl 6 & CLINICAL, August 14
NEUROLOGY, PART II, CLINICAL, September 11
QUALITY ASSURANCE EVALUATION, 3 days, Seplember 14
SPECIALTY REVIEW ORTHOPAEDICS, August 25
ESSENTIALS OF ELECTROCARDIOGRAPHY, 5 days, Seplember 18
EKG FOR ANESTHESIOLOGISTS, 5 days, Seplember 18
SPECIALTY REVIEW DERMATOLOGY, 5 days, Seplember 25
SPECIALTY REVIEW OBSTETRICS & GYNECOLOGY, September 25
CURRENT TOPICS IN INTERNAL MEDICINE, Seplember 25
SEXUAL MEDICINE, 5 days, Seplember 25
CLINICAL & LABORATORY DIAGNOSIS OF HEMORRHAGIC AND THROMBOTIC DISORDERS, 2 days, Oclober 20
MANAGEMENT OF COMMON FRACTURES, 5 days, October 23
SPECIALTY REVIEW SURGERY, PART I, Oclober 23
RECENT ADVANCES IN PSYCHIATRY, 5 days, October 23

*Information concerning numerous other continuation courses available upon request.*

**Address:**
**REGISTRAR, 707 South Wood Street,**
**Chicago, Ill. 60612**

# ISMS Guide to Continuing Medical Education

Compiled for Illinois physicians by the
ILLINOIS COUNCIL ON CONTINUING MEDICAL EDUCATION
55 E. Monroe St., Suite 3510 • Chicago, IL 60603 • (312) 236-6110

*Items for this Calendar must be received 90 days prior to the event. Those received earlier may appear in up to three monthly issues.*

*WARNING! Items for this Calendar come from many sources, often far in advance of the publication date. Sometimes, cancellations or changes in date, place or time occur too late to be corrected before publication. You are urged to contact the sponsoring organization to confirm information given below.*

## AUGUST

### *Emergency Medicine*

**SEVENTH ANNUAL TRAUMA CRITICAL CARE SYMPOSIUM**
**For:** All emergency medical personnel. Lecture/technique sessions, Chicago, IL. **Beginning dates:** 8/31, 9/1. **Fee:** $70. **Reg. limit:** 800. **Sponsor:** Illinois Department of Public Health Services, Division of Emergency Medical Services, 160 North LaSalle, Chicago, IL 60601. **Co-Sponsors:** American Trauma Society, Illinois Chapter; Emergency Department Nurses Association, Illinois Chapter. **Contact:** Penny Finn, Coordinator, 525 West Jefferson, Springfield IL 62761. **Phone:** 217-785-2080.

### *Family Medicine*

**PRIMARY CARE: A VIEW TOWARD THE 80'S**
**For:** Family Physicians, Internists, Pediatricians. 3-day conference (½ day each day), August 17-19, Interlaken Lodge/Villas, Lake Geneva, Wisconsin. **CME credit:** AMA, Category 1, 15 hours. **Fee:** $80. **Sponsor:** Dept. of Medical Education, Ravenswood Hospital Medical Center, 4550 No. Winchester, Chicago, IL 60640. **Contact:** Mara Harrington, Secretary. **Telephone:** 312-878-4300.

### *Internal Medicine*

**STATE & NATIONAL BOARD REVIEW, BASIC**
**For:** Internists. 6½ day lecture, August 6-12, Chicago, IL. **Speaker:** Sheldon S. Waldstein, M.D. **CME Credit:** AAFP Prescribed, 58 hours; AMA Category 1, 58 hours. **Fee:** $275. **Reg. limit:** 150. **Sponsor:** Cook County Graduate School of Medicine, 707 South Wood Street, Chicago, IL 60612. **Contact:** Robert J. Baker, M.D., Dean. **Phone:** 312-733-2800.

### *Internal Medicine*

**STATE & NATIONAL BOARD REVIEW, CLINICAL**
**For:** Internists, family practitioners. Lecture, August 14-19, Chicago, IL. **Speaker:** Sheldon S. Waldstein, M.D., **CME credit:** AAFP Prescribed, 53 hours; **AMA** Category 1, 53 hours. **Fee:** $250. **Reg. limit:** 150. **Sponsor:** Cook County Graduate School of Medicine, 707 South Wood Street, Chicago, IL 60612. **Contact:** Robert J. Baker, M.D., Dean. **Phone:** 312-733-2800.

### *Internal Medicine*

**THE HOLISTIC APPROACH IN THE CARE OF THE INDIVIDUAL WITH MALIGNANCY**
**For:** Physicians, residents, interns. 1-hour lecture, August 23, 11:00 a.m.-12:00 noon (lunch follows), Auditorium, Martha Washington Hospital 4055 N. Western, Chicago, IL. **Speaker:** John Louis, M.D., Professor of Medicine, University of Health Sciences, Chicago Medical School. **Reg. deadline:** 8/22. **Reg. limit:** none. **Fee:** none. **CME Credit:** AAFP Elective, 1 hour; AMA Category 1, 1 hour. **Sponsor:** Medical Staff of Martha Washington Hospital. **Contact:** Fernando Villa, M.D. **Phone:** 312-583-9000 x 331.

### *Orthopaedics*

**SPECIALTY REVIEW IN ORTHOPAEDICS**
**For:** Orthopaedists. 7 day lecture, August 13-19, Chicago, IL. **Speaker:** Peter C. Altner, M.D. **CME credit:** AAFP Elective, 64 hours; AMA Category 1, 64 hours. **Fee:** $275. **Reg. limit:** 350. **Sponsor:** Cook County Graduate School of Medicine, 707 South Wood Street, Chicago, IL 60612. **Contact:** Robert J. Baker, M.D., Dean. **Phone:** 312-733-2800.

### *Physical Medicine & Rehabilitation*

**ELECTROMYOGRAPHY & CLINICAL NEUROPHYSIOLOGY**
**For:** Physiatrists & interested Physicians. 3-day course, August 16-18, Chicago, IL. **CME credit:** AMA Category 1, 21 hours. **Reg. limit:** 40. **Fee:** $175, physicians; $90, residents. **Sponsor:** Rehabilitation Institute of Chicago, 345 E. Superior St., Chicago, IL 60611. **Co-Sponsor:** American Academy of Physical Medicine & Rehabilitation. **Contact:** Victoria Severson, AAPM&R. **Telephone:** 312-236-9512.

## SEPTEMBER

### *Cancer*

**FIFTH ANNUAL CHICAGO SYMPOSIUM "CANCER IMMUNOLOGY: EXPERIMENTAL AND CLINICAL"**
**For:** Oncologists, Surgeons, Internists, Hematologists. 3-day symposium, September 13-15, Pick-Congress Hotel, Chicago. **Speaker:** George Mathe, M.D., Director, Institute of Cancerologie Et D'Immunogenetique, Paris. **CME credit:** AMA Category 1, 16 hours. **Reg. deadline:** 9/1. **Reg. limit:** 200. **Fee:** $70. **Sponsor:** ITR-Biomedical Research of the University of Illinois 115 So. Sangamon St., Chicago, IL. **Co-Sponsors:** Illinois Cancer Council, American Cancer Society. **Contact:** Nancy Piekarski. **Telephone:** 312-996-4688.

### *Clinical Laboratory Correlation*

**For:** Physicians. Lecture/Discussion, Sept. '78-June '79, (Thursdays, bi-weekly), Mattoon, IL. **CME credit:** AMA Category 1. **Fee:** none. **Reg. limit:** none. **Sponsor:** Sarah Bush Lincoln Health Center, R.R. 16, Box 372, Mattoon, IL 61938. **Contact:** Byron Ruskin, M.D. **Telephone:** 217-258-2514.

### *Hypnosis*

**WORKSHOP ON CLINICAL HYPNOSIS**
**For:** Physicians, Dentists, Psychologists. 4-day workshop, September 14-17, Chicago, IL. **CME credit:** AMA Category 1, 25 hours; Academy of General Dentistry, 25 hours. **Fee:** $225. **Reg. limit:** none. **Sponsor:** American Society of Clinical Hypnosis—Education and Research Foundation, 2400 E. Devon Ave., Suite 218, Des Plaines, IL 60018. **Contact:** William F. Hoffman, Jr. **Telephone:** 312-297-3317,

### *Infectious Disease/Urology*

**21ST MEDICAL/SURGICAL SEMINAR FOR LAKE COUNTY**
**For:** M.D.'s, D.D.S.'s, R.N.'s, Rh.P.'s Seminar, September 20, 8:00 AM-1:00 PM, Waukegan, IL **CME credit:** AAFP Elective, 5 hours; AMA Category 1, 5 hours. **Reg. deadline:** 9/20. **Reg. limit:** none. **Fee:** $2.50, staff; $5.00, non-staff. **Sponsor:** St. Therese Hospital, 2615 Washington, Waukegan, IL 60085. **Contact:** R. M. Adelman. **Telephone:** 312-688-5800.

### *Internal Medicine*

**CARDIAC EMERGENCY**
**For:** all Physicians. Symposium, September 26, Vandalia, IL. **CME credit:** AAFP Elective, 3 hours; AMA Category 1, 3 hours. **Reg. limit:** none. **Sponsor:** Southern Illinois University School of Medicine, P.O. Box 3926, Springfield, IL 62708. **Contact:** Lorrain Stephenson. **Telephone:** 217-782-7711.

### *Internal Medi*

**IMMUNOLOGY AND IMMUNODEFICIENCIES DISORDERS**
**For:** all Physicians. Symposium, September Quincy, IL. **CME credit:** AAFP Elective, 4 h AMA Category 1, 4 hours. **Reg. limit:** none. Spo Southern Illinois University School of Medicine, Box 3926, Springfield, IL 62708. **Contact:** Lo Stephenson. **Telephone:** 217-782-7711.

### *Internal Medi*

**MANAGEMENT OF OFFICE UROLOGICAL PROBLE**
**For:** all Physicians. Symposium, September 14, Carmel, IL. **CME credit:** AAFP Elective, 4 hours; Category 1, 4 hours. **Reg. limit:** none. **Sponsor:** S ern Illinois University School of Medicine, P.O. 3926, Springfield, IL 62708. **Contact:** Lorraine henson. **Telephone:** 217-782-7711.

### *Internal Medi*

**UPDATE ON CLINICAL IMMUNOLOGY SYMPOSIU (RESCHEDULED)**
**For** all Physicians. Symposium, September 7, Ca dale, IL. **CME credit:** AAFP Elective, 4 hours; Category 1, 4 hours. **Reg. limit:** none. Spo Southern Illinois University School of Medicine, Box 3926, Springfield, IL 62708. **Contact:** Lo Stephenson. **Telephone:** 217-782-7711.

### *Internal Medi*

**PERSPECTIVES IN CHRONIC MEDICINE**
**For:** M.D.'s. 4-day course, September 20-23, Chi IL. **Sponsor:** American College of Physicians, Pine St., Philadelphia, PA 19104. **Cosponsor:** N western University Medical School. **CME Credit:** Category 1, 24 hours. **Reg. limit:** 80. **Fee:** member/FACP/residents, $216; ACP Associate, nonmember, $288. **Contact:** Linda Salsinger. P 215-243-1200.

### *Medi*

**A STEP-BY-STEP APPROACH IN THE DIAGNOSIS OF ANEMIA**
**For:** Physicians, residents, interns. Lecture, Sep ber 20, 11:00 a.m.-12:00 noon (lunch follows), torium, Martha Washington Hospital, 4055 N. Wes Chicago, IL. **Speaker:** John Louis, M.D., Pr sor of Medicine, University of Health Scie Chicago Medical School. **CME Credit:** AAFP Elec 1 hour; AMA Category 1, 1 hour. **Fee:** none. **limit:** none. **Reg. deadline:** 9/19. **Sponsor:** Me Staff of Martha Washington Hospital. **Contact:** nando Villa, M.D. **Phone:** 312-583-9000 x 331.

### *Medicine, Surg*

**INTRAVENOUS HYPERALIMENTATION & DISEASE**
**For:** all interested Physicians. Lecture, September 7:45 p.m., Chicago, IL. **Speaker:** Stanley J. Duc M.D., Professor & Chairman, Dept. of Surgery. versity of Texas Medical School, Houston. **CME cr** AMA Category 1, 2 hours. **Reg. deadline:** none. none. **Sponsor:** Louis A. Weiss Memorial Hos 4646 No. Marine Dr., Chicago, IL 60640. **Co-Spo** Alfred A. Strauss Memorial Lecture. **Contact:** Bar Millman. **Telephone:** 312-878-8700 x 304.

### *Occupational Medi*

**FALL SEMINAR**
**For:** Physicians, Nurses, Hygienists. 1½-day sem September 8-9, East Moline, IL. **CME Credit:** Elective, 8 hours; AMA Category 1, 8 hours. **Fee:** **Reg. limit:** none. **Sponsor:** Central States Occ tional Medical Assn., 119 Shabbona Drive, Forest, IL 60466. **Contact:** Rita Packer. **Phone:** 747-8124.

*Ophthalmology*

**BETIC RETINOPATHY SYMPOSIUM, PTICAL ASPECTS**
F M.D.'s, residents. 1-day symposium, September 2 8:00 a.m.-5:00 p.m., Chicago, IL. **Speaker:** pe U. Huamonte, M.D. **Sponsor:** University of Illi- Eye & Ear Infirmary, 1855 W. Taylor, Chicago, 60612. **CME Credit:** AMA Category 1. **Fee:** $100. R. limit: none. **Contact:** Dawn Fischer. **Phone:** 312-9 8023.

*Ophthalmology*

**I-ANNUAL COURSE FOR ANTERIOR AND TERIOR SEGMENT VITRECTOMY**
F Ophthalmologists. 2-day course, September 22- 2 University of Illinois Eye & Ear Infirmary, Chi- , IL. **CME credit:** AMA Category 1, 16 hours. R limit: 15. **Fee:** $250. **Sponsor:** Dept. of Oph- mology, University of Illinois, 1855 W. Taylor, C ago, IL 60612. **Contact:** Carmen Carrasco. **Tele- e:** 312-996-8024.

*Orthopedics*

**K INJURIES & BACK PAIN RELATED TO SPORTS URIES**
F all Physicians. Symposium, September 13, Wood r, IL. Reg. limit: none. **CME credit:** AMA Cate- 1, 4 hours; AAFP Elective, 4 hours. **Sponsor:** hern Illinois University School of Medicine, P.O. B 3926, Springfield, IL 62708. **Contact:** Lorraine henson. **Telephone:** 217-782-7711.

*Pediatrics*

**IATRIC REVIEW**
F all Physicians. Symposium, September 28, Sparta, **CME credit:** AAFP Elective, 4 hours; AMA Cate- 1, 4 hours. **Reg. limit:** none. **Sponsor:** Southern ois University School of Medicine, P.O. Box 3 . Springfield, IL 62708. **Contact:** Lorraine Step- on. **Telephone:** 217-782-7711.

*Pediatrics*

**OND ANNUAL SYMPOSIUM ON MEDICAL ETICS**
F all Physicians. 1-day symposium, September 15, ngfield, IL. **CME credit:** AAFP Elective, 7 hours; A Category 1, 7 hours. **Reg. limit:** none. **Sponsor:** hern Illinois University School of Medicine, P.O. B 3926, Springfield, IL 62708. **Contact:** Lorraine henson. **Telephone:** 217-782-7711.

*Pediatrics/Obstetrics*

**FT CONCEPT MULTI-DISCIPLINARY CONCEPT TMENT AND MANAGEMENT OF THE FT LIP/PALATE PATIENT**
F Obstetricians, Pediatricians. 1-day symposium, tember 20, 9:00 a.m.-4:00 p.m., Chicago, IL. C Credit: AMA Category 1, 6 hours. **Fee:** $35. R deadline: 9/10. **Contact:** Eugene V. Tanski, ., 845 N. Michigan, Suite 925W, Chicago, IL 11. **Phone:** 312-642-4619.

*Physical Medicine & Rehabilitation*

**RD ANNUAL COURSE ON MANAGEMENT OF THE AL CORD INJURED PATIENT**
F Physicians & professionals in acute spinal cord agement. 5-day course, September 11-15, Chi- , IL. **CME credit:** AMA Category 1, 32 hours. F $200, physicians; $125, residents. **Reg. limit:** 1 **Sponsor:** Rehabilitation Institute of Chicago, 3 E. Superior St., Chicago, IL 60611. **Co-Sponsor:** rican Academy of Physical Medicine and Rehabili- n. **Contact:** Victoria Severson, AAPM&R, 30 No. igan, Chicago, IL 60611. **Telephone:** 312-236- 9 .

*Physical Medicine & Rehabilitation*

**SPECTIVES IN CHRONIC MEDICINE**
F Physiatrists & Family Physicians. 4-day course, tember 20-23, Chicago, IL. **Reg. deadline:** 8/31. C credit: AMA Category 1, 20 hours. **Reg. limit:** 8 **Fee:** $200, physicians; $150, residents, nurses, d health personnel. **Sponsor:** Rehabilitation In- te of Chicago, 345 E. Superior St., Chicago, IL 6 1. **Co-Sponsors:** American Academy of Physical cine & Rehabilitation, American College of Phy- ns, Northwestern University Medical School. **Con-** Victoria Severson, AAPM&R, 30 No. Michigan, C ago, IL 60611. **Telephone:** 312-236-9512.

**VISITING PROFESSOR PROGRAM**
**For:** Physicians, students, residents. Lecture, Sept. '78-May '79 (2nd Wednesday/mo.), 9:00 AM-4:00PM, VA Hospital, The Chicago Medical School, North Chicago, IL. **CME credit:** AMA Category 1, 5 hours (ea. session). **Reg. limit:** none. **Reg. deadline:** none. **Fee:** none. **Sponsor:** Dept. of Surgery, UHS/CMS, VA Hospital, North Chicago, IL 60064. **Contact:** Karen Jonasson. **Telephone:** 312-473-9200 x 202.

*Surgery*

**PRE-OPERATIVE CARE OF THE SURGICAL PATIENT**
**For:** all Physicians. Symposium, September 21, East St. Louis, IL. **CME credit:** AAFP Elective, 4 hours; AMA Category 1, 4 hours. **Reg. limit:** none. **Sponsor:** Southern Illinois University School of Medicine, P.O. Box 3926, Springfield, IL 62708. **Contact:** Lorraine Stephenson. **Telephone:** 217-782-7711.

*Surgery*

**INTRAVENOUS ALIMENTATION AND DISEASE**
**For:** Physicians. 1-hour lecture, September 19, 7:30 p.m., Wallach Auditorium, Weiss Memorial Hospital, 4646 N. Marine Dr., Chicago, IL 60640. **Speaker:** Stanley J. Dudrick, M.D., Professor and Chairman of Surgery, University of Texas Medical School, Houston. **CME Credit:** AMA Category 1. **Fee:** none. **Reg. deadline:** none. **Sponsor:** Louis A. Weiss Memorial Hospital. **Cosponsor:** Dept. of Surgery, University of Illinois. **Contact:** Anita Robins. **Phone:** 312-878-8700 x 455.

*Surgery, Family/General Practice, Emergency Medicine*

**COMMON PROBLEMS IN HAND INJURIES**
**For:** Practicing Physicians/Surgeons. 1-day symposium, September 23, 8:30 a.m.-5:00 p.m., St. Louis, MO. **Sponsor:** Continuing Medical Education, Washington University School of Medicine, Box 8063, 660 S. Euclid, St. Louis, MO 63110. **CME Credit:** AAFP Elective, 6.5 hours; AMA Category 1, 6.5 hours; AOA, 6.5 hours. **Fee:** $60. **Reg. limit:** 150. **Contact:** Loretta Giacoletto. **Phone:** 314-454-3873.

*Thoracic Diseases and Internal Medicine*

**SCREENING PROGRAMS IN EARLY DIAGNOSIS OF LUNG CANCER**
**For:** Physicians, residents. Lecture, September 6, Auditorium, Martha Washington Hospital, 4055 N. Western Ave., Chicago, IL 60618. **Speaker:** David R. Sanderson, M.D., Mayo Medical School, Rochester, MN. **CME credit:** AAFP Elective, 1 hour; AMA Category 1, 1 hour. **Reg. limit:** none. **Fee:** none. **Sponsor:** Martha Washington Hospital Medical Staff. **Contact:** Fernando Villa, M.D. **Telephone:** 312-583-9000 x 331.

# *OCTOBER*

*Biomed*

**FOURTH ANNUAL MEDICAL PHOTOGRAPHY WORKSHOP**
**For:** all physicians. 1-day symposium/workshop, October 28, Springfield, IL. **Sponsor:** SIU School of Medicine, P.O. Box 3926, Springfield, IL 62708. **CME Credit:** AAFP Elective, 6 hours; AMA Category 1, 6 hours. **Reg. limit:** none. **Contact:** Lorraine Stephenson. **Phone:** 217-782-7711.

*Diabetes*

**RECENT ADVANCES IN DIABETES**
**For:** residents and attending staff. Lecture, October 25, 11:00 a.m. (lunch follows), Martha Washington Hospital, 4055 N. Western, Chicago, IL 60618. **Speaker:** Arthur H. Rubenstein, M.D., Professor and Associate Chairman, Dept. of Medicine, The University of Chicago. **CME Credit:** AAFP Elective, 1 hour; AMA Category 1, 1 hour. **Fee:** none. **Reg. limit:** none. **Reg. deadline:** 10/24. **Sponsor:** Martha Washington Hospital. **Contact:** Fernando Villa, M.D. **Phone:** 312-583-9000 x 331.

*Hypnosis*

**ANNUAL WORKSHOP ON CLINICAL HYPNOSIS**
**For:** Physicians, Dentists, Psychologists. 3-day workshop, October 9-11, St. Louis, MO. **Sponsor:** American Society of Clinical Hypnosis, 2400 E. Devon, Suite 218, Des Plaines, IL 60018. **CME Credit:** AMA Category 1, 24 hours. **Fee:** $225. **Reg. limit:** none. **Cosponsor:** American Society of Clinical Hypnosis—Education and Research Foundation. **Contact:** William Hoffman, Jr. **Phone:** 312-297-3317.

*Internal Medicine*

**DIABETES MELITUS**
**For:** all Physicians. Symposium, October 5, Mt. Vernon, IL. **CME Credit:** AAFP Elective, 4 hours; AMA Category 1, 4 hours. **Sponsor:** SIU School of Medicine, P.O. Box 3926, Springfield, IL 62708. **Reg. limit:** none. **Contact:** Lorraine Stephenson. **Phone:** 217-782-7711.

*Internal Medicine, Family Practice, Pediatrics*

**CLINICAL ALLERGY FOR PRACTICING PHYSICIANS**
**For:** Physicians. 3-day symposium, October 5-7, St. Louis, MO. **Sponsor:** Continuing Medical Education, Washington University School of Medicine, Box 8063, 660 S. Euclid, St. Louis, MO 63110. **CME Credit:** AAFP Elective, 16 hours; AMA Category 1, 16 hours; AOA, 16 hours. **Fee:** $150. **Reg. limit:** 150. **Contact:** Loretta Giacoletto. **Phone:** 314-454-3873.

*Medicine and Surgery*

**MEDICAL AND SURGICAL APPROACHES TO ACUTE COLON AND RECTAL DISEASES**
**For:** Physicians. Symposium, October 26, Hillsboro, IL. **Sponsor:** SIU School of Medicine, P.O. Box 3926, Springfield, IL 62708. **CME Credit:** AAFP Elective, 4 hours; AMA Category 1, 4 hours. **Reg. limit:** none. **Contact:** Lorraine Stephenson. **Phone:** 217-782-7711.

*Neurology*

**NEUROLOGY UPDATE**
**For:** Physicians. Symposium, October 7, Pittsfield, IL. **Sponsor:** SIU School of Medicine, P.O. Box 3926, Springfield, IL 62708. **CME Credit:** AAFP Elective, 4 hours; AMA Category 1, 4 hours. **Reg. limit:** none. **Contact:** Lorraine Stephenson. **Phone:** 217-782-7711.

*Neurotology*

**CLINICAL NEUROTOLOGY**
**For:** Otologists, Neurotologists. 4-day course, October 16-19, Chicago, IL. **Speaker:** Nicholas Torok, M.D. **Sponsor:** Dept. of Otolaryngology, ALS.M., Illinois Eye & Ear Infirmary, Neurotology Section, 1855 W. Taylor, Chicago, IL 60612. **Cosponsor:** American Neurotology Society. **CME Credit:** AMA Category 1, 28 hours. **Fee:** $300. **Contact:** Nicholas Torok, M.D. **Phone:** 312-996-6517.

*Psychiatry*

**ILLINOIS PSYCHIATRIC SOCIETY 5th ANNUAL FALL WEEKEND MEETING**
**For:** Psychiatrists, other physicians. 3-day lecture/workshop, October 6-8, Hyatt Regency O'Hare, Chicago, IL. **Sponsor:** Illinois Psychiatric Society, 55 E. Monroe, Suite 3510, Chicago, IL 60603. **CME Credit:** AMA Category 1, 13.5 hours. **Fee:** $35. **Reg. limit:** none. **Reg. deadline:** 9/25. **Contact:** Wendy Smith. **Phone:** 312-782-1654.

*Surgery*

**CLINICAL CONGRESS**
**For:** Physicians. 5-day lecture, October 16-20, San Francisco, CA. **Sponsor:** American College of Surgeons, 55 E. Erie, Chicago, IL 60611. **CME Credit:** AMA Category 1. **Contact:** Ginny Clark. **Phone:** 312-664-4050.

## RECENT CME ACCREDITATION RECOMMENDATIONS

**The ISMS Committee on CME Accreditation has recently recommended to LCCME approval of the CME programs of the following institutions:**

**Alexian Brothers Medical Center**
**Elk Grove Village**
**Central DuPage Hospital**
**Winfield**
**Chicago Pediatric Society**
**Community Memorial General Hospital**
**LaGrange**
**Cook County Hospital**
**Chicago**
**DuPage County Medical Society**
**Lombard**
**Henrotin Hospital**
**Chicago**
**Institute for Psychoanalysis**
**Chicago**
**Rockford Memorial Hospital**
**Roosevelt Memorial Hospital**
**Chicago**

# CLASSIFIED ADVERTISING

## POSITIONS & PRACTICE OPPORTUNITIES

**FULL TIME PHYSICIAN** for Industrial Clinic in Skokie. Surgical experience needed. Salary negotiable. Must have Illinois license. Call (312) 674-4800, Mrs. McCubbin.

**OPPORTUNITIES FOR PHYSICIANS IN INDIANA**—There are several excellent openings among the Indiana State Hospitals at various locations throughout the state for psychiatrists and physicians of other specialties, at most experience levels. A newly-revised salary schedule offers a very competitive income plus a generous package of fringe benefits. An adjunct practice is possible beyond the regular working hours and on-call responsibilities. Please reply with a copy of the c.v. to: Farabee & Associates, Inc., P.O. Box 472, Murray, KY 42071 or call (collect) (502) 753-9772. Farabee is retained by the Indiana Department of Mental Health.

**ACADEMIC DIRECTOR, INTERNAL MEDICINE:** University of Illinois affiliated community hospital seeks individual to be responsible for undergraduate, graduate and continuing medical education, and administration of residency and outpatient center. Physician we seek must be American Board of Internal Medicine certified. In return we offer a challenging and rewarding experience plus a competitive salary and benefit program. Send resume in complete confidence to: Box 917, c/o IMJ, 55 E. Monroe, Suite 3510, Chicago 60603.

**WANTED: INDUSTRIAL PHYSICIAN:** Unusual opportunity for Illinois licensed physician. Full time industrial work with minor traumatic surgery and physical examinations. Regular hours. Advancement for right person. Starting salary negotiable. Write to Box 920, c/o IMJ, 55 E. Monroe, Suite 3510, Chicago, 60603.

**PHYSICIAN WANTED:** Family Practitioner, Board Eligible or Certified, full time position. Chicago suburban group with complete diagnostic facilities. Excellent starting compensation. Profit sharing and pension program. Pleasant working conditions. Capable interested medical associates. Convenient location, regular hours, good hospital affiliation, vacations. Insurance benefits include life, hospitalization, catastrophic medical expense, disability and malpractice. Medical Society and hospital dues paid by corporation. Call collect: Eugene J. Scherba, M.D., or Administrator, Thomsen Clinic, Ltd. (312) 849-2400.

**ORTHOPEDIC SURGEON** who desires to locate in a rural area of southern Illinois needed to serve two community hospitals. One hour from St. Louis. Good educational system for children. Excellent recreation. Reply: T. K. Janssen, Administrator, Washington County Hospital, Nashville, Illinois 62263.

**WANTED—M.D.**, certified Family Practice, to direct and establish Family Practice Residency. Please reply to Box 927, c/o IMJ, 55 E. Monroe, Suite 3510, Chicago, 60603.

**ENT SPECIALIST** needed in a large, fast growing Chicago suburb. No other ENT specialist in town. Very favorable terms. Send resume to Box 926, c/o IMJ, 55 E. Monroe, Chicago, Illinois 60603.

**DERMATOLOGIST** needed for a large, fast growing Chicago suburb. Solo practice. Ideal for a second office. Office space available in a new medical complex. Very favorable terms. Send resume to Box 928, c/o IMJ, 55 E. Monroe, Chicago, Illinois 60603.

**OVERHEAD MOUNTING? WORKING LONG HOURS?** Consider working in a University Health Service. 40 hour week—positive fringe benefits including generous vacation times. Illinois license. Equal opportunity/affirmative action employer. Contact: M. M. Torray, M.D., Illinois State University, Normal, Illinois 61761. Tel.: 309-438-8655.

**PHYSICIAN WANTED:** Internist, board certified, full time to join Chicago suburban group with complete diagnostic facilities. Excellent starting compensation, profit sharing and pension program. Pleasant working conditions. Capable, interested medical associates. Convenient location, regular hours and good hospital affiliations, vacations. Insurance benefits include Life, Hospitalization, Catastrophic Medical Expense, Disability for Illness and Accident and Malpractice. Medical society and hospital dues paid by corporation. Call collect: Eugene J. Scherba, M.D. or Administrator, Thomsen Clinic, Ltd. (312) 849-2400.

**MATTOON—CHARLESTON, ILLINOIS.** Sara Bush Lincoln Health Center Emergency Department has July opening for qualified physician. Guarantee $50,000-$55,000 with ideal working conditions and schedule. Send curriculum vitae to Stephen Allin, M.D., Emergency Department Director, P.O. Box 372, Mattoon, Illinois 61938 or call toll free 1-800-325-3982 for details.

**EMERGENCY DEPARTMENT PHYSICIAN:** Become part of an expanding, dynamic multispecialty clinic in midwest university community of 100,000. Excellent salary, benefits. Write or call Medical Director, Carle Clinic, Urbana, IL 61801, (217) 337-3239.

**GYNECOLOGIST NEEDED** for new fully operational multi-specialty clinic in Libertyville. For information call 312-362-9097.

**FAMILY PRACTITIONER**—To associate with one senior general practitioner and one surgeon in rural southern Illinois. Excellent educational system and recreation. Financially sound community. One hour from St. Louis. JCAH 72-bed hospital in Nashville. Association available now. Contact: T. K. Janssen, Administrator, Washington County Hospital, Nashville, Illinois, (618) 327-8236.

**PHYSICIAN WITH EMPATHY TOWARD COLLEGE AGE** population to practice general medicine in 38 bed accredited hospital with large outpatient clinic. Salary negotiable. Excellent fringe benefits. Contact L. W. Combs, M.D., Director, Purdue University Student Hospital, West Lafayette, IN 47907, (317) 749-2441. Equal access/equal opportunity employer.

## FOR SALE, LEASE OR RENT

**MEDICAL OFFICE SUITE FOR RENT,** Lincoln-Belmont Bldg. 715-1200 square feet, available at once in full service, elevator, active professional building. Call Gary Solomon, (312) 334-5400.

**MEDICAL CENTER FOR RENT.** Complete and ready to open. 4300 sq. ft. at 2301 E. 95th Street, Chicago. Large waiting rm., 18 exam rms., x-ray rm., central a/c & heat. Call Gary Solomon, (312) 334-5400.

**SUITE TO LEASE** for Internist, Pediatrician, Psychologist, Psychiatrist or other medical practice. Suite is located in a high quality building with a growing medical community situated across from a major hospital. The complex already includes an outstanding lab, X-ray facility, pharmacy and 16 professionals. Arrangement provides flexibility for the new tenant to share a suite with an existing practice, to have office built in newly created bare space and to participate in the ownership and direction of the complex. STRONG Property Managers, Ltd. Agents, 201 W. Springfield, Champaign, IL 61820. (217) 356-2617.

**SPACIOUS** Northside Lakeview area medical office for rent. Newly remodeled. Five examining rooms, carpeted. Large furnished waiting room. Available now. Interested in Spanish speaking doctors only. Growing Spanish speaking area. Near Ashland-Lincoln and Belmont. Pharmacy space also availble, if desired. Please contact: Dr. Pedro O. Cabrera (Dentist) at 1442 W. Belmont or call (312) 528-0068.

**FOR SALE:** 31-year-old established general practice and clinic. Fully equipped and furnished. Clinic and practice can accommodate two doctors. Contact: Bob Billa, 2931 East Southcross Blvd., San Antonio, Texas 78212.

**LISLE-MEDICAL SUITE** available in prestigious modern building located on Rt. 53 in Lisle. X-ray facilities on premises. Zone controlled heating and air conditioning. Ample parking. Call 969-2850.

## SITUATIONS WANTED

**DIAGNOSTIC RADIOLOGY**—Board eligible. Well trained in ultrasound, CAT scan. Part or full time. Also for film reading. Call (312) 771-8076.

**DR. P. J. REDDY**—Male, 39 years—Psychiatry, M.D., D.P.M., F.R.C.P.(C), ABPN, with total ten years of wide experience in Psychiatry with Illinois license looking for place in private practice or a salaried job.

**DR. P. V. REDDY**—Female, 34 years—OB-GYN, M.D., M.R.C.O.G. (U.K.), American Board Certified with Illinois license. Total ten years in OB-GYN. Looking for place in private practice or a salaried job. Please contact Dr. P. J. Reddy, Union Hospital, Moose Jaw, Saskatchewan, Canada. Office—(306) 692-1841; Home—(306) 693-3288.

**BOARD CERTIFIED RADIOLOGIST,** 40, graduate of American medical school available for film reading in office, clinic or home. Daily pick-up service if desired. Excellent references. Please contact Illinois Medical Journal, Box No. 930, 55 East Monroe, Chicago, Illinois 60603.

## GUARANTY FUND CERTIFICATE

**GUARANTY FUND CERTIFICATE** issued by the Illinois State Medical Inter-Insurance Exchange for sale. Coverage $100,000/$300,000. Class 5, Specialty: Otorhinolaryngology. Original purchase price $6,840.00. Interested: Contact Olawale O. Idewu, M.D. 9204 South Commercial Avenue, Chicago, Illinois 60617; Tel. (312) 735-8033 or 734-4243.

**GUARANTY FUND CERTIFICATE:** Class 4, Territory 1 for $1 Million/$1 Million. Moving out of state. Purchase price $2572 in 1976. Please reply to Box 921, c/o IMJ, 55 E. Monroe, Suite 3510, Chicago 60603.

**ISMIE GUARANTY FUND CERTIFICATE:** Price (original) $6024.00. Specialty: OB-GYN, Class V, Territory II. Have moved out of Illinois. Discount price. Will be available, Thomas T.H. Lin, M.D. 175 N. Jackson Ave., Suite 208, San Jose, CA 95116, (408) 251-5205.

**GUARANTY FUND CERTIFICATE:** Class 8 Inter-Insurance Exchange Certificate for sale (previously class 5). Call 266-1977, 9-5 P.M.

**ILLINOIS STATE MEDICAL INTER-INSURANCE EXCHANGE** Guaranty Fund Certificate #1160 Territory II Class 5 (1 mil/1 mil) OB-GYN for sale. Orig. price $6024. Best offer. Left state. Contact. M. Hosseinipour, M.D., c/o P.O. Box 681, Williamson, W.Va. 25661. (606) 237-1020 or 237-1083.

**GUARANTY FUND CERTIFICATE** for sale at discount. Phone (312) 579-0133.

**ILLINOIS STATE MEDICAL INTER-INSURANCE EXCHANGE** Guaranty Fund Certificate for sale. Territory 1 Class 1—Purchase price $772. Best offer. Please contact Mrs. Burton at 388-8052.

**GUARANTY FUND CERTIFICATE** issued by the Illinois State Medical Inter-Insurance Exchange for sale. Coverage $100,000/$300,000. Original purchase price $6,024.00. Interested call (312) 963-8777 or 920-8792.

**GUARANTY FUND CERTIFICATE**—Anesthesiologist relocating, Class 5, 1,000,000/1,000,000 coverage. Original price 10,000—purchase price 8000.00 or best offer. Favorable conditions may be arranged. Send inquiries to Box 922, c/o IMJ, 55 E. Monroe, Suite 3510, Chicago, 60603.

**GUARANTY FUND CERTIFICATE** for sale. This certificate is worth $3096 toward your purchase of any Class III, IV or V certificate. Will discount price. Call evenings 312-293-1993.

**FOR SALE:** Illinois Medical Inter-Insurance Exchange Guaranty Fund Certificate, 100,000/300,000, Class 1, Terr. I. Cost 1977, one thousand-thirty two dollars ($1032.00). Contact: Hans F. Waecker, D.O., 5200 S. Ellis Ave., Chicago 60615.

*IMJ and ISMS are not acting as brokers or agents; this is provided as a membership service.*


★

*Specialized Service*

IN

PROFESSIONAL LIABILITY INSURANCE

*is a high mark of distinction*

THE

MEDICAL PROTECTIVE COMPANY

FORT WAYNE, INDIANA

*Professional Protection Exclusively since 1899*

CHICAGO AREA OFFICE:

T. J. Pandak, J. C. Kunches, L. R. Gannon, and W. G. Prangle, Representatives

814 Commerce Drive, Suite 101B, Oak Brook, Illinois 60521 (312) 325-7314

SPRINGFIELD OFFICE: W. J. Nattermann, Representative

426½ South Fifth Street, Springfield 62701 (217) 544-2251

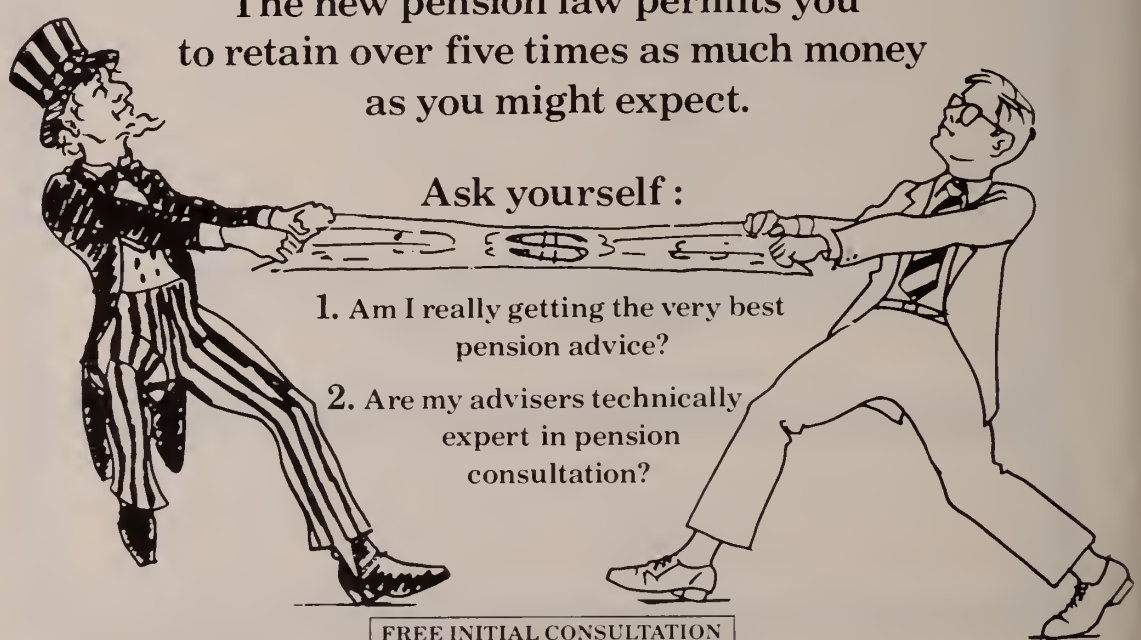
# EKG

*(Continued from page 6)*

**Answers: 1. A 2. E.**

The ECG shows atrial flutter with 2:1 atrioventricular block. The atrial rate is 430 and the ventricular response is 215 beats per minute, respectively. The sharp flutter waves are seen best in the right precordial leads, notably $RV_4$, or the $V_4$ position on the right precordium. In an older patient, the tall R waves in lead V, and $RV_4$ would indicate right ventricular hypertrophy. However, at this age, the R wave in $RV_4$ can go to 12 mm and the R wave in $V_1$ to 20mm. This is due to the normal right ventricular preponderance seen in the first months of life. Digitalis was given and the ventricular response slowed, but the atrial flutter did not convert to sinus rhythm. Quinidine, 15mg every six hours, was added with further control of the heart rate but without conversion to sinus rhythm. Since atrial flutter is so rare in normal hearts, it was decided to do a right heart catheterization to rule out any left to right shunts and measure pressures in the pulmonary artery, right ventricle, right atrium, and pulmonary capillary wedge position. All pressures were normal. A small left to right shunt was found at the atrial level and was felt to be compatible with a patent foramen ovale or small atrial septal defect. Direct current cardioversion at 7 watt-seconds converted the atrial flutter to normal sinus rhythm. Maintenance digitalis and quinidine were eventually discontinued. The child has continued normally and now, at age four years, has a normal chest X-ray and ECG. This patient had a normal heart by catheter studies and in follow-up examinations. The etiology of the atrial flutter was never explained. This shows that the significance of atrial flutter is closely bound to the underlying cardiac pathology.


**The new pension law permits you to retain over five times as much money as you might expect.**



**Ask yourself:**

1. Am I really getting the very best pension advice?
2. Are my advisers technically expert in pension consultation?

FREE INITIAL CONSULTATION

American Society Pension Actuaries
Consultants to the Chicago Medical Society Employees Pension Plan
National Association Pension Consultants

Mann, Levine & Weiss, Ltd. 3525 W. Peterson, Chicago, IL 60659

(312) 539-7820 Pension Consultants and Plan Designers (312) 539-7820

# *Abstracts of Board Actions*

*(Continued from page 4)*

In other PSRO-related action, ISMS will introduce a resolution at the AMA Annual Meeting—June 18-22 in St. Louis—urging AMA to seek legislation that would exempt PSROs from the Freedom of Information Act. A U.S. District Court recently declared that a Washington, D.C.-area PSRO is an "agent" of the federal government and thereby is required to disclose identified PSRO data under the Information Act. In outlining procedures to alleviate the breach of confidentiality problem, the court pointed out that the remedy lies with Congress, not the courts.

## '79 Board Meeting Dates

The 1979 Board of Trustees meeting schedule is:

Jan. 27-28 — Palmer House or Ambassador West
Mar. 10-11 — (location not yet determined)
May 5-9 — Palmer House (Annual Meeting of House of Delegates)
June 14 — (one-day session devoted primarily to council & committee appointments plus emergency items)
Sept. 15-16 — Ambassador West
Nov. 9-11 — Holiday Inn, Decatur (Interim Session of House of Delegates)

## Liaison Committee With Bar Association

ISMS and Illinois Bar Association will each name three representatives to a Liaison Committee to resolve increasing problems between physicians and lawyers. The Chicago Medical Society and Chicago Bar Association will be invited to each name two members. ISMS representatives will include: Drs. Mike Murphy, Belleville; Robert Fox, Glenview; and Donald Aaronson, Chicago.

## AMA Jail Project

ISMS will be one of 10 state medical societies added to the list of participants in the AMA Program to Improve Health Care in Jails. The Society will receive a $5,000 grant from the Law Enforcement Assistance Administration—through AMA—to set up and administer the project.

## AMA Dues Billing

The Board endorsed the AMA Criteria for Dues Billing & Remittance which states:

> Each society receiving AMA dues should forward AMA dues and a list of the payers of the dues within 30 days of receipt of the dues. All dues collected within the last 30 days prior to the AMA delinquency date should be forwarded in time to reach the AMA prior to that delinquency date.

By agreeing to the criteria, ISMS will be reimbursed by the AMA on the following formula basis:

2% of dues received by the AMA no later than January 15.
1.5% of dues received by AMA no later than February 15.
1% of dues received by AMA no later than March 15.
.5% of dues received by AMA after March 15.

The foregoing will be shared on an equitable basis with those component societies involved in the billing process.

## CME Accreditation

ISMS will seek accreditation to grant Category I credit for CME programs. This will allow the Society more freedom in programming and eliminate the need to secure co-sponsors for programs in order to offer the Category I credit. Accreditation is granted by the National Liaison Committee on Continuing Medical Education.

## IDPA Drug Manual

The following drugs were approved for inclusion in the IDPA Drug Manual: Limbitrol, Depakene (Valproic Acid), Theodur, Hydergine R-Oral tablets (automatic), Ocusert, Benylin Cough Syrup (automatic), Deconamine (list to Chlorpheniramine), Decubitex (under dermatological preparations) and Metamucil (21 oz. dose available).

## Designated Products

Next month, the Illinois Dangerous Drugs Commission is expected to act on proposed scheduling of Talwin into Schedule II of the Controlled Substances Act . . . and review a proposal by the Dangerous Drugs Advisory Committee to classify the drug as a "designated product."

## Conference on Cost Effectiveness

The ISMS Task Force on Cost Effectiveness will sponsor a June 14 conference on health care costs. The session—a followup to a similar program last February—will be attended by representatives of labor, management, insurance, banking, local and state government. Focus of the day-long session will be the role of physicians and hospitals in cost containment.

## Appointments/Nominations

Several hundred ISMS members were appointed to one-year terms on the Society's various councils and committees for 1978-79. Appointed Council chairmen were: Drs. Norman Frank, Clarendon Hills, Affiliate Societies; Michael Murray, Olney, Economics and Peer Review; Charles McHugh, Chicago, Education and Manpower; Tassos Nassos, Chicago, Governmental Affairs; Eugene Vickery, Lena, Medical-Legal; Glen Tomlinson, Lincoln, Medical Service; Arthur Traugott, Urbana, Mental Health and Addiction; and Mack Hollowell, Charleston, Public Relations and Membership Services.

## Legislation

The Board voted to oppose the following pending legislation which would:

- Amend current certificate-of-need law to conform to federal provisions and extend the definition of "health care facilities" to kidney treatment centers. Local health planning agencies would be required to coordinate planning procedures with provisions of the federal Social Security Act and Public Law 93-641.
- Reduce the IDPA appropriation for medical assistance by $54 million.
- Add to the list of grounds for suspension or revocation of a license the suspension or termination from participation in Medicaid, provided such suspension was based on gross and willful misconduct. If it appears impossible to defeat this bill, ISMS will seek to remove provisions referring to *suspension* from Medicaid as grounds for revocation of a license.

The Board voted to support pending legislation which would:

- Allow license renewal fees—currently earmarked only for the Medical Disciplinary Board—to be used for costs related to license renewal and administration of licensing requirements pertaining to continuing medical education.
- Direct Title XIX Public Aid payments for treatment in state medical facilities into the Mental Health Fund administered by IDMHDD. This would allow greater flexibility in the use of these funds to provide patient care.
- Appropriate an addition $20 million in Fiscal '79 for Medicaid payments to physicians.

Pending a favorable review by legal counsel, ISMS will support a proposal which would allow a plea of "guilty, mitigated by mental illness," in criminal cases. The Board agreed that this proposal—embodied in HB 2755—was more acceptable than another bill which would eliminate the current plea of "not guilty by reason of insanity."

ISMS will vigorously work to amend legislation dealing with a new Mental Health Code to insure that hospital admission (including voluntary certification), treatment and discharge procedures for mental or physical illness shall be—without exception—the responsibility of a physician licensed to practice medicine in all its branches. The pending legislation allows non-medical personnel to participate in involuntary commitment procedures.

ISMS will seek to amend legislation which would permit emergency medical personnel to perform procedures without direct physician authorization when conditions prevent direct voice contact with a hospital or physician supervisor. ISMS will attempt to limit such activity to procedures specifically listed in the protocol books required for study prior to certification.

The Illinois Constitution requires abolition of the personal property tax. A proposal pending in the General Assembly would institute an income tax on corporations and partnerships as well as other entities as a method of replacing revenue lost through abolition of the property tax. ISMS will oppose the bill—HB 2418—and support an amendment calling for a two-year delay on any action to replace the property tax.

ISMS will send a delegation to Washington to meet with Illinois Senators and voice objection to SR 2410 which would extend certificate-of-need to physician offices.

## Ambulatory Surgical Treatment Centers

The Board endorsed the concept of allowing Ambulatory Surgical Treatment Centers (ASTC) to maintain repositories for controlled substances provided such repositories are registered and maintained in keeping with current regulations. Presently, ASTCs may have a limited pharmacy and each physician practicing at a center may have his own supply. The Board agreed that more stringent rules are necessary and authorized the Council on Mental Health and Addiction to draft amendatory legislation if needed.

## Alcoholism

ISMS will seek to amend Illinois statutes so that physicians may treat minors for alcohol intoxication without parental consent. A legislative interpretation of alcohol as a drug will be necessary to include intoxication as a form of drug abuse, thereby allowing confidential treatment.

The Board voted to encourage the IDMHDD's Division of Alcoholism to prepare a program for physicians to use in educating women as to the health risks posed to a fetus by moderate to heavy consumption of alcohol during pregnancy. The Board also directed the Council on Mental Health and Addiction to consider working with the Dangerous Drugs Commission in formulating a similar program concerning risks to the fetus posed by other drug usage during pregnancy.

ISMS will distribute to members an insert for the Physician Desk Reference explaining the interaction effect of alcoholic beverages with commonly-prescribed medications. Costs of printing and distribution will be covered by an educational grant from the IDMHDD Division of Alcoholism.

NONPARTISAN

# IMPAC

**ILLINOIS MEDICAL POLITICAL ACTION COMMITTEE**
55 East Monroe Street
Chicago, Illinois 60603
312/782-1963

## WHERE ARE YOUR CANDIDATES?

Fellow Physicians:

It is July,1978. By the time your read this the spring session of the General Assembly will have ended. Incumbent legislators and newcomers alike will be home in their districts organizing for the fall election campaigns. Are you organized to help the best candidates get elected?

Across Illinois,physicians and their spouses are voluntarily and temporarily uniting to form physician candidate support committees. Physicians throughout Illinois take part in the elective process by supporting the candidates of their own preferences. Through this support, physicians influence the selection of those who ultimately decide what course government is to follow. Through active participation, physicians can effectively contribute toward assuring that there will be an open channel of communication between medicine and government when legislation is being considered that will affect the profession and the public. Remember, in today's society, politics cannot be separated from government. To have a voice in government, political activity is necessary. And in this case political activity doesn't just mean giving money. Money helps but money by itself doesn't win elections. Elections are won by votes and those votes are won by the hard work of many people. Physicians and their families must be well organized to provide the help that will elect superior candidates.

IMPAC can help you organize. For further information write: IMPAC, 55 East Monroe Street, Chicago, Illinois 60603. And do so now,so that you can organize immediately to provide maximum support to the candidates of your choice.

Herbert Sohn, M.D.

Herbert Sohn, M.D.
Chairman

P.S. If you are not a member of IMPAC please join immediately. Only through active participation in our organization can we implement good legislation.

Contributions are not limited to the suggested amount. Neither the Illinois State Medical Society nor the AMA will favor or disadvantage anyone based upon the amounts of or failure to make pac contributions. Copies of IMPAC & AMPAC reports are filed with and are available for purchase from the Federal Election Commission, Washington, D.C. Contributions are subject to the limitations of FEC regulations, Sections 110.1, 110.2 & 110.S. (Federal regulations require this notice.) IMPAC reports are also filed with the State Board of Elections, and are or will be available for purchase from the State Board of Elections, 1020 South Spring Street, Springfield, Illinois 62704.

# Doctor's News

**LICENSES ONCE ISSUED, MUST BE RENEWED**—It recently has been noted before the Medical Examining Committee of the Department of Registration and Education that some physicians may be practicing with expired licenses.

Licenses, once issued, must be renewed every two years, on the first of July, even-numbered years.

Technically, if a license is not so renewed a physician is practicing without a license. During such practice, it is conceivable that professional liability insurance, even though purchased, will not provide coverage or defense against claims.

In addition, several instances have been identified in which a physician's spouse or office personnel have renewed a deceased person's license.

License renewal is accomplished through the Medical Examining Committee, Department of Registration and Education, 628 East Adams, Springfield, Illinois 62786. If one has not received a renewal notice for July 1, 1978, please write or call immediately (217) 782-7934.

It is recommended that physicians bring this to the attention of their fellow practitioners, to their hospital staff members, and to their county medical societies. If a physician has not renewed his license since it was issued, and it was issued prior to July 1, 1976, it may very well have lapsed. Serious problems could ensue.

**HOSPITAL CME OPPORTUNITY**—The Ohio Medical Education Network (OMEN) has announced that memberships are available for the 1978-79 program schedule. OMEN is a telephone network for physicians, supplying CME lectures from the Ohio State University. One hour of AMA Category 1 credit is available for each of 30 weekly programs, which are broadcast at 11:00 a.m. for one hour. Ten Illinois hospitals currently hold membership in OMEN.

The programs are conducted for small group seminars, and consist of a 30 minute lecture and 30 minute discussion through a closed-circuit amplified telephone. Cost to interested hospitals is determined on a sliding scale based upon bed capacity. Visual aids and outlines are mailed to participating hospitals one week before each session. The deadline for membership application is July 26, 1978, but a limited number of late applications may be accepted. For further information on specific lectures and costs, contact: Arthur Bartfray, CCME, A-352 Starling-Loving, 320 W. 10th Ave., Columbus, Ohio 43210.

**NATIONAL CONFERENCE ON THE IMPAIRED PHYSICIAN**—The third AMA conference on treatment of physicians impaired due to alcoholism, drug dependence or mental illness will be held September 29-October 1 at the Sheraton Ritz Hotel in Minneapolis, Minnesota. Conference participants will attend lectures and workshops regarding programs sponsored by state medical societies, hospitals and medical boards, and participate in discussion groups on all aspects of the problem. For further information, please contact: AMA, Department of Meeting Services, 535 N. Dearborn St., Chicago, 60610, before September 8, 1978.

**COST VICTORY REPORTED**—Rockford Memorial Hospital has announced a reduction in its daily room rates by $1.50 per day, for private and semi-private rooms in medical/surgical, pediatric and rehabilitation units. In announcing the decrease, spokesmen attributed the savings in comprehensive professional liability insurance premiums this year, due to favorable claims-experience.

**UPCOMING MEETINGS**—The World Federation of Nuclear Medicine and Biology will hold their second international congress September 17-21, in Washington, D.C. Approximately 3,000 nuclear medicine specialists from six continents are expected to attend. Further information may be obtained by writing: WFNMB Second International Congress, 1629 K Street, N.W., Suite 700, Washington, D.C. 20006.

The American Academy of Occupational Medicine and American Academy of Industrial Hygiene will hold their joint annual meeting September 19-22 in Williamsburg, Virginia. The regular scientific sessions on September 20-22 will be preceded by two postgraduate seminars on the first day of the conference. For further information contact the American Academy of Occupational Medicine, 150 N. Wacker Dr., Chicago 60606.

**PHYSICIANS IN THE NEWS**—**Silvio Aladjem, M.D.**, Chicago, is the new professor and chairman of the department of obstetrics and gynecology for Loyola University Medical Center in Maywood. . . . **Frederick D. Malkinson, M.D.**, Chicago, has been elected to serve as vice president for the Society for Investigative Dermatology. . . . The Illinois Society of Pathologists has elected new officers. **John G. Dietrich, M.D.**, Springfield, **Peter J. Soto, M.D.**, Belleville, **Marshall H. Short, M.D.**, River Forest, and **James C. Pritchard, M.D.**, Geneva, will form the new roster of officers.

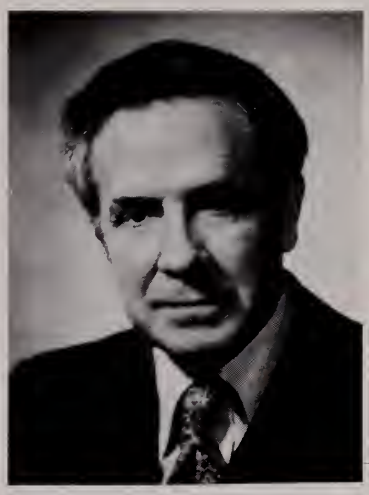
**Robert J. Becker, M.D.**, Joliet, recently received the sixth annual Clemens von Pirquet award from Georgetown University in Washington, D.C. The award recognizes work as a national lobbyist in legislation regarding the Clean Air Bill, drug reform measures and issues related to immunologic and allergic health problems. . . . The Chicago Society of Industrial Medicine and Surgery recently elected **Meredith E. Keller, M.D.**, to serve as their new president. Other new officers included **John J. Brosnan, M.D.**, vice president and **Robert S. Kassriel, M.D.**, Secretary-Treasurer.

Four Chicago plastic surgical resident physicians recently received awards for research papers presented to the Chicago Society of Plastic Surgery. First place awards were given to **William Georgis, M.D.**, and **John O. Kucan, M.D. Frank Madda, M.D.**, and **Raymond E. Shively, M.D.**, received second place awards for their work.

**AN ERROR—COMPOUNDED**—In the May Doctor's News, erroneous information was contained in the item entitled "Controlled Substance Update." The June issue unsuccessfully attempted to correct the error, but again the facts were inadvertently misstated. This is regretted and apologies are extended.

The story, based upon Dangerous Drugs Commission information, should have stated that there is a *proposal* to place Phencyclidine (PCP) and Pentazocine (Talwin) in Schedule II. Currently PCP is in Schedule III; Pentazocine is *not* scheduled on the current Controlled Substance List. This proposal has been published in the "Illinois Register" and will be acted upon by the Dangerous Drugs Commission (DDC) at its August 1, meeting. Interested parties may send comments to the DDC, 300 N. State Street, Chicago, 60610. DDC action will be reported in forthcoming issues.

## *President's Page*



# Mandatory CME

This month marked the first license renewal period requiring evidence of CME credits. Although the requirement is reasonable, it has been sharply criticized by some physicians. Perhaps the criticism reflected an "off-the-cuff" reaction rather than thoughtful consideration of the details or the alternative.

The alternative was re-examination. In this age of public accountability, the drive to impose a re-examination requirement had gained considerable momentum before it was diffused by enactment of the CME law.

Most physicians agree that CME is needed to keep abreast of developments in their particular fields of medicine. In fact, surveys indicate that the majority of physicians voluntarily have been logging enough credits to meet the requirement. For these physicians, the Illinois law merely demands documentation of ongoing activities.

The requirement of 100 hours every two years should not prove burdensome even to those few physicians who largely have ignored CME opportunities. *It averages out to a total of less than one hour per week!*

Obviously, mandatory CME is an acceptable alternative to re-examination for relicensure. In addition, it represents a documented effort by physicians to maintain the highest possible standard of care. This enhances the profession's credibility—our most effective weapon in the fight to retain our professional freedom. ◄

David S. Fox, M.D., President

# Physician Recruitment Program

*In an effort to reduce the number of towns in Illinois needing physicians, the Physician Recruitment Program and the Doctor's Job Fair, are publishing synopses in the Journal.*

*Physicians who are seeking a place to practice or who know of any out-of-state physicians seeking an Illinois residence are asked to notify the Program.*

*Any areas wishing to be listed should contact: Mrs. E. Duffy, Physician Recruitment Program, ISMS, 55 E. Monroe, Suite 3510, Chicago, 60603.*

**CHICAGO:** Opportunities Available for Family Practitioners in a single specialty clinic setting. Association as a satellite facility with a 265 bed community hospital. Opportunity to build own practice with financial assistance available. Contact: Teryl R. Filebark, 1044 N. Francisco Ave., Chicago 60622. (312) 278-8800. (9)

**CHICAGO** (desirable suburb): Older general practitioner has excellent office facilities to share with younger G.P. Objective: need help with practice. Younger man may have guarantee to take over practice in near future. Hospital staff appointment available. All replies confidential. Box MK, Physician Recruitment Program, ISMS. (9)

**ELGIN:** Psychiatrist, ¾ time position with CMHC. Provide leadership and direction of medical and psychiatric aspects of clinical program, consult with staff, provide direct service to a wide variety of patients. Experience: past residency, preferably Board certified. Resume and salary requirements would be helpful to: Jack Crook, Director of Programs, Fox Valley Mental Health Center, 384 Division, Elgin, 60120, (312) 695-1115. (10)

**FAIRBURY:** Population 3,500. Rural area serving a population of more than 16,000. Excellent practice opportunity for family practitioner or internist interested in family practice. Enjoy life and your practice in an area which offers excellent facilities and a personal, friendly atmosphere; join the staff of 112-bed JCAH accredited community hospital. Write: Frank Brady, Administrator, Fairbury Hospital, Fairbury, 61739, or call collect (815) 692-2346. (10)

**FORT MADISON, IOWA:** Openings for 2-4 FP/GP, Ped., in growing industrial city of 16,000 serving 70,000 on Mississippi River. Solo, partnership, clinic available. Substantial salary, other incentive. U. of Ia. near, excellent living area, 125 bed accredited hospital. Contact Donald A. Buckert, Fort Madison Community Hospital, Fort Madison, Ia. 52627. (319) 372-6530. (7)

**FREEPORT:** Internist-general internist or internist with sub-specialty, board certified or eligible to join multi-specialty group in community of 35,000 in Northern Illinois. Excellent salary first year then partnership. Excellent retirement and fringe benefits. Send curriculum vita and references to K. H. Shons, Business Manager, Freeport Medical Clinic, Ltd., 3103 West Stephenson Road, Freeport, 61032. (815) 235-6131 (7)

**HERRIN:** Population 10,000. Trade area 40,000. Located in beautiful vacationland of Southern Illinois, near major university and medical school. Family Practice and OB-Gyn needed. Solo or clinic available. Excellent financial program provided. Modern well equipped hospital. Call collect or write, Larry Feil, Herrin Hospital, Herrin, 62948—Tel. (618) 942-4710. (7)

**MENDOTA:** General practice, second physician for Wholistic Health Center of Mendota, Illinois. Innovative program with additional staff for counseling and patient education. Excellent local hospital. Future openings available in five other Wholistic Health Centers in the planning stage. Call or write: Lucy Young, M.D., 607 Tenth Ave., Mendota, 61342. (815) 539-3888 (7)

**MINIER:** General or family practitioner for rich agricultural area near Bloomington. Large practice waiting due to death of doctor. Office with X-ray and other equipment, very reasonable. Unusual opportunity. Contact: Harvey Graff, Minier 61759. (309) 392-2345 or 392-2120. (10)

**OSWEGO:** Family physician or internist to join group of four in a small town primary care clinic. Two full-service hospitals nearby. One hour west of Chicago. Dr. A. Haan, Oswego, 60543. (312) 554-8431. (11)

**OTTAWA:** Opening in fields of Internal Medicine and Family Practice with multi-specialty group of nine physicians. Community, 20,000 plus. 154 bed hospital under five years old. Latest equipment One and one-half hours from Chicago and Peoria. Near State Parks. Excellent school system. Close to Jr. College and State Universities. Salary negotiable. CONTACT: Mrs. Van Buren, Ottawa Medical Center, 313 W. Madison, Ottawa 61350. (815) 433-1010. (10)

**PEORIA:** Emergency physician—Unique opportunity to start on the ground floor with fee-for-service group in 550-bed medical center seeing 27,000 ER visits. Need career-minded physician for three 16-hour shifts per week with four weeks paid vacation. Compensation 57K with excellent corporate benefits plus incentive compensation. Flexible scheduling to allow individual pursuits in university town of 250,000 in Central Illinois. Contact: Hospital Emergency Physicians S.C., 221 Northeast Glen Oak, Peoria, 61636; phone 309-672-4974. (8)

**UNION COUNTY:** Population 17,000. Clinic and office facilities available for family practitioner and physician of internal medicine. Special Care Unit under construction in County Hospital. Nearby cities of Carbondale and Cape Girardeau 25 miles away. Recreational facilities plentiful. Contact: E. A. Helfrich, 517 N. Main, Anna, 62906 AC 618-833-5155. (7)

**WAUKEGAN:** Population 67,000, northern Chicago Suburb. Newly remodeled medical center near hospital. Looking for Internist, Family Physician. Contact Washington Center, 1515 Washington St., Waukegan 60085, Y. Lee, M.D. 312-336-2221 or 729-5407. (9)

# A Difference in Theophylline Therapy

## micro-pulverized BRONKODYL® Capsules

brand of theophylline, USP anhydrous



- Blood levels as fast as an elixir
- With minimal gastric irritation*

*Please see complete prescribing information, a summary of which follows.

**E RIPTION:**
ac green and white hard gelatin capsule contains theophylline USP anhy- 200 mg., in a micro-pulverized form. Each brown and white hard gelatin e contains 100 mg. The elixir contains 80 mg. theophylline per 15 ml. 0% alcohol elixir (approximately 20 calories, 0.9 gm carbohydrate per bl poonful).

**N:** Theophylline is a methylxanthine which relaxes the smooth muscu- of the bronchioles through its inhibition of the conversion of cyclic de sine monophosphate to adenosine monophosphate by phosphodiester- also has diuretic, cardiotonic, and CNS stimulant effects.

**ATIONS:** Bronchodyl is indicated for symptomatic relaxation of bronchiolar in the chronic obstructive bronchopulmonary diseases; e.g., bronchial , chronic bronchitis and pulmonary emphysema.

**RAINDICATIONS:** Bronchodyl is contraindicated in persons known to ad serious idiosyncratic responses to theophylline, its salts, or the other xanthines, theobromine, or caffeine and may be contraindicated in peptic

**INGS:** All methylxanthines should be used with caution in children and in who are currently taking bronchodilator products, especially in rectal form, which may contain theophylline or related drugs.

**E IN PREGNANCY:** Although theophylline has been used for many with no evidence of adverse fetal effect or teratogenicity, its safety in ncy has not been established. Therefore use of Bronkodyl during lacta- in women of childbearing potential requires that possible benefits of the e weighed against possible hazards to fetus or child.

**UTIONS:** Bronkodyl should be used with caution in patients with cardiac ulatory disease.

**ADVERSE REACTIONS:** Gastrointestinal: Epigastric distress, nausea, vomiting. Cardiovascular: palpitations. CNS: Insomnia, restlessness, irritability, convulsion.

**DOSAGE AND ADMINISTRATION:** Adults: Usual dosage of Bronkodyl is 200 mg. every 6 hours (four doses in each 24 hours). This dosage may be adjusted to reflect individual clinical response as an indication of slow or rapid metabolism of the drug. If adverse reactions are encountered, each dose may be reduced, or the interval between doses may be lengthened, or both. If clinical response is not satisfactory, indicating possible rapid inactivation of the drug, dosage may be gradually increased to achieve the desired response. In some instances of either too slow or too rapid metabolism, plasma levels of theophylline should be determined and dosage adjusted accordingly to achieve levels above 10 mcg/ml, but not to exceed 20 mcg/ml.

Dosage in Children: Usual dosage should be based on administration of 10 mg per kg per 24 hours, divided in 4 doses per day, given every 6 hours. As this may not be possible with use of the capsules, Bronkodyl elixir may be used. Theophylline saliva levels (approximately 60% of simultaneous blood levels), may facilitate dosage adjustments, especially in children, to obtain appropriate response.

**HOW SUPPLIED:**
Bronkodyl 100 mg., brown and white capsules in 100's, Code #1831.
Bronkodyl 200 mg., green and white capsules in 100's, Code #1833.
Bronkodyl Elixir, 80 mg. per 15 ml, in pints, Code #1835.

BREON LABORATORIES INC.
90 Park Avenue, New York, N.Y. 10016

# COLBY PROCLAIMS WOMAN SUFFRAGE

Signs Certificate of Ratification at His Home Without Women Witnesses.

MILITANTS VEXED AT PRIVACY.

Wanted Movies of Ceremony, But Both Factions Are

WASHINGTON, Aug. 26, 1920—




# Social Security Bill Is Signe
# Gives Pensions to Aged, J

## Roosevelt Approves Message Intended to Benefit 3 Persons When States Adopt Cooperating Laws—Is the Measure 'Cornerstone' of His Economic Pro

WASHINGTON, Au
The Social Security Bi
a broad program of un
insurance and old a
and counted upon to i
20,000,000 persons, bec
day when it was sign
dent Roosevelt in the
those chiefly responsi
ting it through Co

Mr. Roosevelt cal
"the cornerstone
which is being
me s c ple

# SENATE APPROVES 18-YEAR OLD VOTE IN ALL ELECTIONS

Amendment to Constitution is Sent to House, Where Passage is Expected

WASHINGTON, March 10, 1971—The Senate approved today, 94 to 0, and sen

# TRUMAN CLOSES TED NATIONS CONFEREN WITH PLEA TO TRANSLATE CHARTER INTO DEEDS

# NEW WORLD HOPE

President Hails 'Great Instrument of Peace,' Insists It Be Used

HISTORIC LANDMARK

Meeting Gives Standing Ovation as Executive Pictures Peace Gain

"If we fail to use it," he declared to the solemn final meeting of the delegates, 'we shall betray all of those who have died in order that we might meet here in freedom and safety to create it.'

"If we seek to use it selfishly—for the advantage of any one nation or any small group of nations—we shall be equally guilty of that betrayal."

Fervent Interpolation

The President, speaking in the auditorium of the War Memorial Opera House, built in memory of sons of the Golden Gate city who gave their lives in the first World War, in which he himself served, seemed to give unconscious expression to the solemn feeling of the occasion when, at the outset of his speech, he interpolated the words, half a hope, half a prayer:

"Oh, what a great day this can be in history!"

Just before the plenary session

# UL IGN the Dra Ends N

WASHINGTON, Jan. 27, 1973—"With the signing of the peace agreement in Paris today, and after receiving a report from the



# PATIENT PACKAGE INSERTS: A CONCEPT WHOSE TIME HAS COME?

*The consumer's right to know is an irreversible and desirable trend of the Seventies. It extends, and properly, to a patient's right to know more about his or her prescription medications. One way, gaining favor, is through patient package inserts. Wisely-prepared and properly distributed when medically indicated, they could markedly improve patient knowledge and drug therapy—laudable goals by anyone's standards.*

*The PMA endorses these goals and will work with government, the health professions and consumers to achieve them.*

## The Advantages

The concept holds promise of benefits: better patient understanding of the product prescribed, better adherence to the treatment plan, and more awareness of possible side reactions.

Every doctor has had patients who fail to finish antibiotic regimens because they feel better. Some patients assume that if one tranquilizer or analgesic is good, two may be twice as good. Still others fail to report dizziness while on antihypertensive therapy —and so on.

Problems like these might arise less often if the patient received written information in addition to verbal instructions. Some studies suggest that patients are more receptive to such materials, and they more often understand the verbal instructions and follow them, when inserts are used.

## The Disadvantages

There are also some potential problems. Obviously, the inserts must be clearly phrased, without extraneous or complex detail. How much information is enough? How can it be kept current? Should all patients receive the same information? Should inserts be included with all drugs? Should only potential problems be listed or are patients better off with a "fair balance" presentation that describes usefulness as well as drawbacks?

These and similar questions require answers, since model inserts have yet to be properly developed and tested. Despite the need for these studies, the FDA is proceeding prematurely with inserts on selected products. We think the Congress is the only place where the matter can be given the proper legal status and direction, particularly since it represents a conceptual change in the legal, medical and social framework of the nation's prescription drug information system.

## The Solution

The PMA believes that carefully-devised pilot studies of various kinds of inserts are needed. They should be developed and implemented with full participation by doctors, pharmacists, consumers, communications experts and the drug industry. Such studies will provide reliable pathways to follow, so that inserts will be useful aids to medical practice.

And particularly we think that you should be closely involved in this debate and in these studies and decisions. Otherwise, people with less experience and qualifications may control the purposes, content and use of a tool with considerable promise for improved patient care. It could make a difference in your practice tomorrow, and more importantly, in the health of your patients.

PMA
THE PHARMACEUTICAL MANUFACTURERS ASSOCIATION
1155 FIFTEENTH ST., N. W. WASHINGTON, D. C. 20005

IMJ
Illinois Medical Journal

# YOUR ADVERTISERS

*Our advertisers serve the Medical Profession and support your Journal. All advertisers are approved by your Journal Committee. It will help you and your society to mention your Journal when writing them.*

## Space Representatives

United Media Associates, Inc., 16 Bruce Park Avenue, Greenwich, Conn. 06830

## Pharmaceuticals


55 **Breon Laboratories**
*Bronkodyl*

10-11 **Bristol Laboratories**
*Tegopen*

Cover 2 **Burroughs Wellcome Company**
*Empirin Compound with Codeine*

19-20 **Geigy Pharmaceuticals**
**Div. of Ciba-Geigy Corp.**
*Tofranil—P.M.*

24 **Eli Lilly and Company**
*Darvon*

13-14 **Mead Johnson Laboratories**
*Colace*
*Vasodilan*

3 **Roche Laboratories**
**Div. of Hoffman-LaRoche**
*Librium*

Covers 3&4 **Roche Laboratories**
**Div. of Hoffman-LaRoche**
*Valium*

17 **Upjohn Pharmaceuticals**
*Tolinase*

5 **Warren Teed Laboratories**
*Kaon*


## Insurance


45 **Medical Protective Co.**
*Professional Liability Ins.*

21 **Parker Aleshire and Co.**
*Group Insurance*


## Services and Continuing Education


9 **Bio Science Laboratories**
*Laboratory Service*

7-8 **Blue Cross and Blue Shield**
**Report**

31 **Blue Cross and Blue Shield**
*Assistant Medical Director Wanted*

44-45 **Classified Advertising**

41 **Cook County Graduate School**
*Continuing Medical Education*

42-43 **ISMS Guide to Continuing**
**Medical Education**

18 **Jobst Laboratories**
*Measuring VPGs*

46 **Mann Levine & Weiss**
*Pension Consultants*

56-57 **Pharmaceutical Manufacturers**
**Association**
*Patient Package Inserts*

28 **U.S. Army**
*Recruitment*

**Before prescribing, please consult complete product information, a summary of which follows:**

The effectiveness of Valium (diazepam) in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.

**Contraindications:** Tablets in children under 6 months of age; known hypersensitivity; acute narrow angle glaucoma, may be used in patients with open angle glaucoma who are receiving appropriate therapy.

**Warnings:** As with most CNS-acting drugs, caution against hazardous occupations requiring complete mental alertness (e.g. operating machinery, driving). Withdrawal symptoms (similar to those with barbiturates, alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal muscle cramps, vomiting, sweating). Keep addiction-prone individuals (drug addicts or alcoholics) under careful surveillance because of predisposition to habituation/dependence.

***Usage in Pregnancy:*** **Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations, as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

ORAL Advise patients against simultaneous ingestion of alcohol and other CNS depressants.

Not of value in treatment of psychotic patients; should not be employed in lieu of appropriate treatment. When using oral form adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increase in dosage of standard anticonvulsant medication; abrupt withdrawal in such cases may be associated with temporary increase in frequency and/or severity of seizures.

INJECTABLE *To reduce the possibility of venous thrombosis, phlebitis, local irritation, swelling, and, rarely, vascular impairment when used I.V., inject slowly, taking at least one minute for each 5 mg (1 ml) given; do not use small veins, i.e., dorsum of hand or wrist; use extreme care to avoid intra-arterial administration or extravasation. Do not mix or dilute Valium with other solutions or drugs in syringe or infusion flask. If it is not feasible to administer Valium directly I.V., it may be injected slowly through the infusion tubing as close as possible to the vein insertion.*

Administer with extreme care to elderly, very ill, those with limited pulmonary reserve because of possibility of apnea and/or cardiac arrest; concomitant use of barbiturates, alcohol or other CNS depressants increases depression with increased risk of apnea; have resuscitative facilities available. When used with narcotic analgesic eliminate or reduce narcotic dosage at least 1/3, administer in small increments. Should not be administered to patients in shock, coma, acute alcoholic intoxication with depression of vital signs.

Has precipitated tonic status epilepticus in patients treated for petit mal status or petit mal variant status.

Withdrawal symptoms (similar to those with barbiturates, alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal muscle cramps, vomiting, sweating). Keep addiction-prone individuals under careful surveillance because of predisposition to habituation/dependence. Not recommended for OB use.

Efficacy/safety not established in neonates (age 30 days or less); prolonged CNS depression observed. In children, give slowly (up to 0.25 mg/kg over 3 minutes) to avoid apnea or prolonged somnolence; can be repeated after 15 to 30 minutes. If no relief after third administration, appropriate adjunctive therapy is recommended.

**Precautions:** If combined with other psychotropics or anticonvulsants, carefully consider individual pharmacologic effects—particularly with known compounds which may potentiate action of Valium (diazepam), *i.e.*, phenothiazines, narcotics, barbiturates, MAO inhibitors and antidepressants. Protective measures indicated in highly anxious patients with accompanying depression who may have suicidal tendencies. Observe usual precautions in impaired hepatic function; avoid accumulation in patients with compromised kidney function. Limit oral dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation (initially 2 to 2½ mg once or twice daily, increasing gradually as needed or tolerated).

INJECTABLE Although promptly controlled, seizures may return; readminister if necessary; not recommended for long-term maintenance therapy. Laryngospasm/increased cough reflex are possible during peroral endoscopic procedures; use topical anesthetic, have necessary countermeasures available. Hypotension or muscular weakness possible, particularly when used with narcotics, barbiturates or alcohol. Use lower doses (2 to 5 mg) for elderly/debilitated.

**Adverse Reactions:** Side effects most commonly reported were: drowsiness, fatigue, ataxia. Infrequently encountered were confusion, constipation, depression, diplopia, dysarthria, headache, hypotension, incontinence, jaundice, changes in libido, nausea, changes in salivation, skin rash, slurred speech, tremor, urinary retention, vertigo, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances and stimulation have been reported; should these occur, discontinue drug.

Because of isolated reports of neutropenia and jaundice, periodic blood counts, liver function tests advisable during long-term therapy. Minor changes in EEG patterns, usually low-voltage fast activity, have been observed in patients during and after Valium (diazepam) therapy and are of no known significance.

INJECTABLE Venous thrombosis/phlebitis at injection site, hypoactivity, syncope, bradycardia, cardiovascular collapse, nystagmus, urticaria, hiccups, neutropenia.

In peroral endoscopic procedures, coughing, depressed respiration, dyspnea, hyperventilation, laryngospasm/pain in throat or chest have been reported.

**Management of Overdosage:** Manifestations include somnolence, confusion, coma, diminished reflexes. Monitor respiration, pulse, blood pressure, employ general supportive measures, I.V. fluids, adequate airway. Use levarterenol or metaraminol for hypotension, caffeine and sodium benzoate for CNS-depressive effects. Dialysis is of limited value.

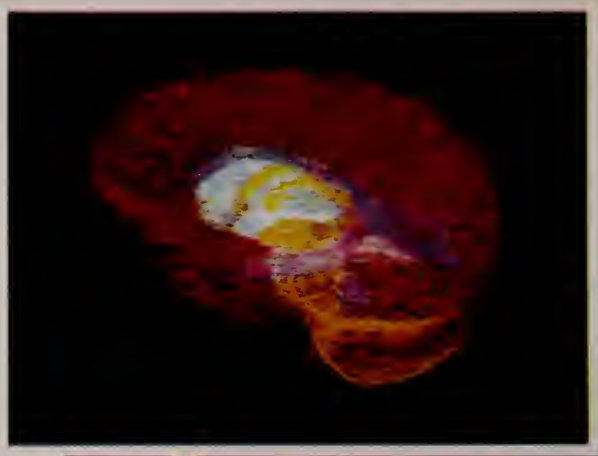
**Supplied:** Tablets, 2 mg, 5 mg and 10 mg, bottles of 100 and 500; Tel-E-Dose® (unit dose) packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10; Prescription Paks of 50, available singly and in trays of 10. Ampuls, 2 ml, boxes of 10; Vials, 10 ml, boxes of 1. Tel-E-Ject® (disposable syringes), 2 ml, boxes of 10. Each ml contains 5 mg diazepam, compounded with 40% propylene glycol, 10% ethyl alcohol, 5% sodium benzoate and benzoic acid as buffers, and 1.5% benzyl alcohol as preservative.

ROCHE

Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

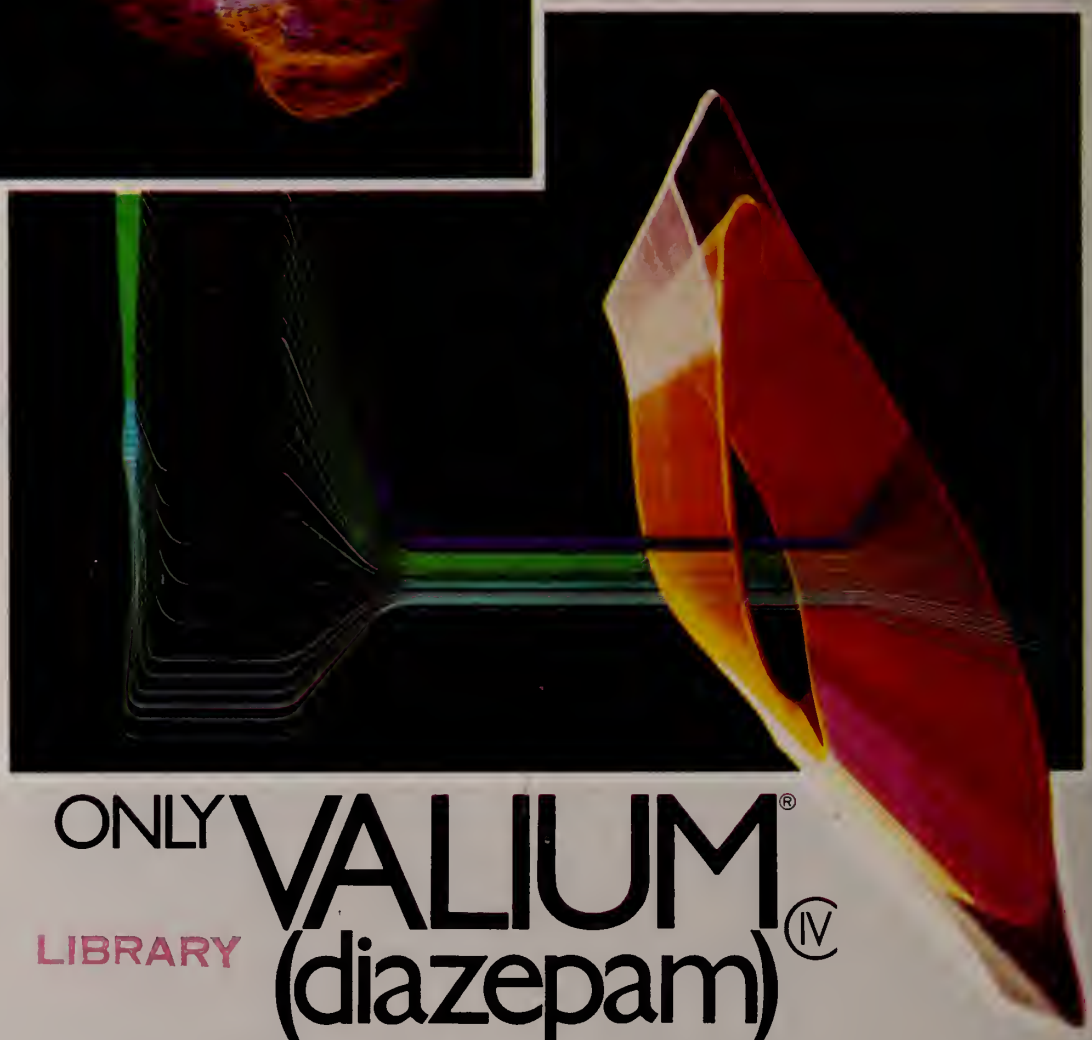



# ONLY VALIUM® (diazepam) GIVES YOU THIS CHOICE OF DOSAGE FORMS AND FLEXIBILITY



PSYCHOTHERAPEUTIC

SKELETAL MUSCLE RELAXANT



ONLY VALIUM® (diazepam) IV HAS THESE TWO DISTINCT EFFECTS

LIBRARY
AUG 9 1978
NEW YORK ACADEMY OF MEDICINE

Please see preceding page for a summary of product information.

ROCHE

# Illinois Medical Journal

OFFICIAL JOURNAL OF THE
ILLINOIS STATE MEDICAL SOCIETY

Volume 154, No. 2, August, 1978

Riv[illegible] Hospital
Medical Library

BALCONY

[illegible] HOSP.
350 N. WALL ST. BOX 749
KANKAKEE, IL 60901

75
[illegible] consultant: MJ series

79
Carcinoma arising in a thyroglossal duct cyst: Diagnostic and treatment criteria for a rare condition

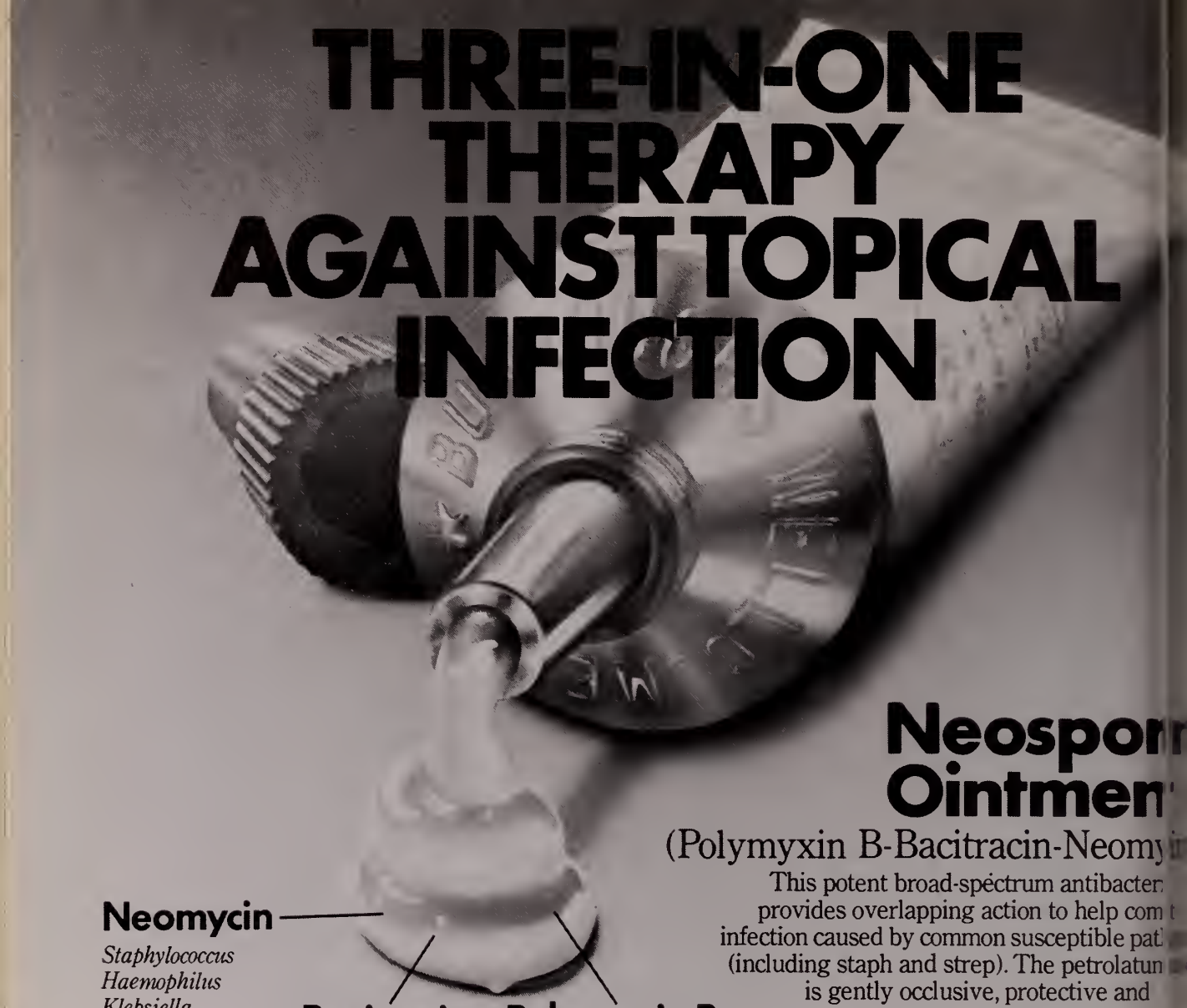
81
The university medical school reaching to the community physician: Academic and community physicians form a beneficial alliance

85
[illegible]mune complexes [illegible] human disease part one of a three-part [illegible]omprehensive [illegible] view): Seminars [illegible]mmunopathology [illegible]nd oncology

90
Computerized whole body tomography: Surgical grand rounds

President's page . . . 105
Table of contents . . . 59

# THREE-IN-ONE THERAPY AGAINST TOPICAL INFECTION



## Neospor Ointmen

(Polymyxin B-Bacitracin-Neomy

This potent broad-spectrum antibacter provides overlapping action to help com infection caused by common susceptible pat (including staph and strep). The petrolatun is gently occlusive, protective and enhances spreading.

**Neomycin**
*Staphylococcus*
*Haemophilus*
*Klebsiella*
*Aerobacter*
*Escherichia*
*Proteus*
*Corynebacterium*
*Streptococcus*
*Pneumococcus*

**Bacitracin**
*Staphylococcus*
*Corynebacterium*
*Streptococcus*
*Pneumococcus*

**Polymyxin B**
*Pseudomonas*
*Haemophilus*
*Klebsiella*
*Aerobacter*
*Escherichia*

*In vitro* overlapping antibacterial action of Neosporin® Ointment (polymyxin B-bacitracin-neomycin).

Wellcome

Burroughs Wellco
Research Triangle
North Carolina 2

---

## Neosporin® Ointment

(Polymyxin B-Bacitracin-Neomycin)

Each gram contains: Aerosporin® brand Polymyxin B Sulfate 5,000 units; zinc bacitracin 400 units; neomycin sulfate 5 mg (equivalent to 3.5 mg neomycin base); special white petrolatum qs; in tubes of 1 oz and 1/2 oz and 1/32 oz (approx.) foil packets.

**WARNING:** Because of the potential hazard of nephrotoxicity and ototoxicity due to neomycin, care should be exercised when using this product in treating extensive burns, trophic ulceration and other extensive conditions where absorption of neomycin is possible. In burns where more than 20 percent of the body surface is affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended.

When using neomycin-containing products to control secondary infection in the chronic dermatoses, it should be borne in mind that the skin is more liable to become sensitized to many substances, including neomycin. The manifestation of sensitization to neomycin is usually a low grade reddening with swelling, dry scaling and itching; it may be manifest simply as failure to heal. During long-term use of neomycin-containing products, periodic examination for such signs is advisable and the patient should be told to discontinue the product if they are observed. These symptoms regress quickly on withdrawing the medication. Neomycin-containing applications should be avoided for that patient thereafter.

**PRECAUTIONS:** As with other antibacterial pre prolonged use may result in overgrowth of no ceptible organisms, including fungi. Appropriat should be taken if this occurs.

**ADVERSE REACTIONS:** Neomycin is a not unc cutaneous sensitizer. Articles in the current lit indicate an increase in the prevalence of pers allergic to neomycin. Ototoxicity and nephroto have been reported (see Warning section).

Complete literature available on request from sional Services Dept. PML.

IMJ

Illinois Medical Journal

AUGUST, 1978 Vol. 154, No. 2 CONTENTS

## Clinical Articles

79 Carcinoma Arising In a Thyroglossal Duct Cyst
*By Phillip L. Cacioppo, M.D., and Mohin T. Samaraweera, M.D.*

## Special Articles

81 The University Medical School Reaching to the Community Physician
*By Richard L. Byyny, M.D., Linda K. Gunzburger, M.S., Chase P. Kimball, M.D., Mark Siegler, M.D., and Alvin R. Tarlov, M.D.*

## Seminars in Immunopathology and Oncology

*Richard J. Ablin, Ph.D., Contributing Editor*

85 Immune Complexes and Human Disease
*By Brian S. Andrews, BSc(Med), and Ronald Penny, M.D.*

## Surgical Grand Rounds

90 Computerized Whole Body Tomography
*John M. Beal, M.D., Contributing Editor*

## President's Page

105 The Illinois Voluntary Effort
*David S. Fox, M.D.*

*(Contents continued on overleaf)*

## CONTENTS (continued)

### *Features*


61 Clinics for Crippled Children
63 EKG of the Month
67 Viewbox
72 New Pharmaceutical Specialties
73 Obituaries
75 Ask a Consultant
95 Housestaff News
96 Pulse of the ISMS Auxiliary
98 Guest Editorial
103 Doctor's News
108 Illinois Society, American Association of Medical Assistants
109 Classified Advertising
111 ISMS Guide to Continuing Medical Education
115 Physician Recruitment


### *Staff*


**Managing Editor** ..... **Richard A. Ott**
**Assistant Editor** ..... **Mariann M. Stephens**
**Executive Administrator** ..... **Roger N. White**

*(Cover by Jane and C. R. Bushwaller)*

**PUBLICATIONS COMMITTEE**

Herschel Browns, M.D., Chicago, *Chairman*
Kenneth A. Hurst, M.D., Naperville
Robert P. Johnson, M.D., Springfield
Alfred J. Kiessel, M.D., Decatur
Harold J. Lasky, M.D., Chicago

**Editorial Board**

J. William Roddick, Jr., M.D., Springfield, *Chairman*
Eli L. Borkon, M.D., Carbondale
Daniel R. Cunningham, M.D., Wilmette
Raymond A. Dieter, Jr., M.D., Glen Ellyn
James G. Ekeberg, M.D., Palatine
Ediz Z. Ezdinli, M.D., Kenilworth
Carl Neuhoff, M.D., Peoria
Constantine S. Soter, M.D., Arlington Heights
Donald D. VanFossan, M.D., Springfield

Contributor in Surgery: John M. Beal, M.D., Chicago
Contributor in Maternal Death Studies: Robert R. Hartman, M.D., Jacksonville
Contributor in Pediatric Perplexities: Ruth Andrea Seeler, M.D., Chicago
Contributor in Radiology: Leon Love, M.D., Maywood
Contributor in Cardiology: John R. Tobin, M.D., Maywood
Contributor in Immunopathology: Richard J. Ablin, Ph.D., Chicago
Contributor in Rheumatology: L. F. Layfer, M.D., Chicago

**ILLINOIS STATE MEDICAL SOCIETY**

OFFICER

David S. Fox, M.D., Presider
826 E. 61st St., Chicago 6063
P. John Seward, M.D., President-Elec
310 N. Wyman St., Rockford 6110
Herschel Browns, M.D., 1st Vice-Presider
4600 N. Ravenswood, Chicago 6064
G. W. Giebelhausen, M.D., 2nd Vice-Presider
1101 Main St., Peoria 6160
Audley F. Connor, Jr., M.D., Secretary-Treasure
7531 S. Stony Island Ave., Chicago 6064

HOUSE OF DELEGATES

Cyril C. Wiggishoff, M.D., Speake
25 E. Washington, Chicago 6060
Robert P. Johnson, M.D., Vice-Speake
108 Maple Grove, Springfield 6270

TRUSTEES

1st District: 1980, John J. Ring, M.D
511 Hawley, Mundelein 6006
2nd District: 1980, Allan L. Goslin, M.D
712 N. Bloomington, Streator 6136
3rd District: 1979, Alfred Clementi, M.D
675 W. Central Rd., Arlington Heights 6000
3rd District: 1980, Raymond J. Des Rosiers, M.D
1044 N. Francisco, Chicago 6062
3rd District: 1979, Robert T. Fox, M.D
2136 Robincrest, Glenview 6002
3rd District, 1979, Jere Freidheim, M.D
3050 S. Wallace, Chicago 6061
3rd District: 1981, Morris T. Friedell, M.D
7531 S. Stony Island Ave., Chicago 6064
3rd District: 1981, Henrietta Herbolsheimer, M.D
5528 S. Hyde Park Blvd., Apt. 1202, Chicago 6063
3rd District: 1981, Lawrence L. Hirsch, M.D
2434 Grace St., Chicago 6061
3rd District: 1980, Harold J. Lasky, M.D
55 E. Washington, Chicago 6060
3rd District: 1980, Richard N. Rovner, M.D
645 N. Michigan, Suite 920, Chicago 6061
3rd District: 1980, Joseph C. Sherrick, M.D
303 E. Superior, Chicago 6061
4th District: 1979, Fred Z. White, M.D
723 N. Second St., Chillicothe 6152
5th District: 1979, P. F. Mahon, M.D
800 E. Carpenter, Springfield 6270
6th District: 1981, Robert R. Hartman, M.D
1515 A. W. Walnut, Jacksonville 6265
7th District: 1979, Alfred J. Kiessel, M.D
1 Powers Lane Pl., Decatur 6252
8th District: 1979, James Laidlaw, M.D
104 W. Clark, Champaign 6182
9th District: 1981, Warren D. Tuttle, M.D
203 N. Vine St., Harrisburg 6294
10th District: 1981, Julian W. Buser, M.D
6600 W. Main St., Belleville 6222
11th District: 1980, Kenneth A. Hurst, M.D
52 Bunting Lane, Naperville 6054
12th District: 1980, Joseph Perez, M.D
5670 E. State St., Rockford 6110
Trustee-At-Large: George T. Wilkins, M.D
3165 Myrtle, Granite City 6204
Chairman of the Board: Robert R. Hartman, M.D
1515 A. W. Walnut, Jacksonville 6265



Microfilm copies of current as well as some back issues of the *Illinois Medical Journal* may be purchased from Xerox University Microfilm, 300 North Zeeb Road, Ann Arbor, Mich. 48106.

Contents of *IMJ* are listed in the *Current Contents/Clinical Practice.*

Published by the Illinois State Medical Society, 55 E. Monroe St., Chicago, Ill. 60603 (312-782-1654



Copyright, 1978. The Illinois State Medical Society. All material subject to this copyright may be photo copied for the noncommercial purpose of scientific or educational advancement.



Subscription $8.00 per year, in advance, postage prepaid, for the United States, Cuba, Puerto Ric Philippine Islands and Mexico. $10.00 per year for all foreign countries included in the Universal Post Union. Canada $8.50. U.S. Single current copies available at $1.00 ($1.10 by mail), back issues $1.50.

Second class postage paid at Chicago, Ill. When moving please notify Journal office of new addres including old mailing label with notification, if possible. POSTMASTER: Send notice on form No. 3579 t Illinois State Medical Society, 55 E. Monroe St., Chicago, Ill. 60603.

Pharmaceutical advertising must be approved by the ISMS Publications Committee. Other advertisin accepted after review by Publications Committee or Board of Trustees. All copy or plates must reach th Journal office by the fifteenth of the month preceding publication. Rates furnished upon request.

Original articles will be considered for publication with the understanding that they are contributed onl to the *Illinois Medical Journal*. The ISMS denies responsibility for opinions and statements expressed b authors or in excerpts, other than editorial or allied views or statements which reflect the authoritative actio of the ISMS or of reports on official actions, policies or positions. Views expressed by authors do nc necessarily represent those of the Society; any connection with official policies is coincidental.

The *Illinois Medical Journal* is published by the Illinois State Medical Society as an educational an professional informational magazine and distributed as a benefit of membership in the Illinois State Medica Society. Its intent is to keep members current in medical knowledge and is a part of a continuing medica education program. Socioeconomic matters, affecting as they do a changing pattern in the proper delivery c medical care, are considered an inherent element in medical education.

# Clinics for Crippled Children

Thirty-six clinics for Illinois' physically handicapped children have been scheduled for September by the University of Illinois, Division of Services for Crippled Children. The Division will count twenty-five general clinics providing diagnostic orthopedic, pediatric, speech and hearing examination, along with medical, social and nursing services. There will be nine special clinics for children with cardiac conditions and two for children with cerebral palsy. Any private physician may refer to or bring to a convenient clinic any child or children for whom he may want examination or consultative services.

September 1 Division Cardiac—U. of I. at the Medical Center
September 5 Park Ridge Cardiac—Lutheran General Hospital
September 6 Hinsdale—Hinsdale Sanitarium
September 7 Effingham—St. Anthony's Mem. Hosp.
September 7 Sterling—Community General Hospital
September 7 Lake County Cardiac—Victory Memorial Hospital
September 8 Chicago Heights Cardiac—St. James Hosp.
September 11 Peoria Cardiac—St. Francis Hospital
September 12 Carrollton—Boyd Memorial Hospital
September 12 Peoria—St. Francis Hospital
September 12 E. St. Louis—Christian Welfare Hosp.
September 13 Carmi—Carmi Township Hospital
September 13 Rock Island Cerebral Palsy—Foundation for Crippled Children and Adults
September 13 Champaign-Urbana—McKinley Hospital
September 13 Joliet—St. Joseph's Hospital
September 13 Chicago Heights General—St. James Hosp.
September 14 Springfield—St. John's Hospital
September 15 Kankakee Cardiac—St. Mary's Hospital
September 18 Maywood—Loyola Medical Center
September 19 Anna—Union County Hospital
September 19 Rock Island—Moline Public Hospital
September 19 Decatur—Decatur Memorial Hospital
September 19 Belleville—St. Elizabeth's Hospital
September 20 Centralia—St. Mary's Hospital
September 20 Springfield Ped-Neuro—St. John's Hosp.
September 20 Evergreen Park—Little Company of Mary Hospital
September 21 Rockford—Rockford Memorial Hospital
September 21 Elmhurst Cardiac—Memorial Hospital of DuPage County
September 22 Chicago Heights Cardiac—St. James Hospital
September 25 Peoria Cardiac—St. Francis Hospital
September 26 Peoria—St. Francis Hospital
September 26 Alton—Alton Memorial Hospital
September 27 Elgin—Sherman Hospital
September 27 Chicago Heights Gen.—St. James Hospital
September 28 West Frankfort—Union Hospital
September 28 Macomb—McDonough District Hospital

The Division of Services for Crippled Children is the official state agency established to provide medical, surgical, corrective and other services and facilities for diagnosis, hospitalization and after-care for children with crippling conditions or who are suffering from conditions that may lead to crippling. In carrying on its program, the Division works cooperatively with local medical societies, hospitals, the Illinois Children's Hospital-School, civic and fraternal clubs, visiting nurse associations, local social and welfare agencies, local chapters of the National Foundation and other interested groups. In all cases, the work of the Division is intended to extend and supplement, not supplant, activities of other agencies, either public or private, state or local, carried on in behalf of crippled children.

*for August, 1978*


# Librax®

Each capsule contains 5 mg chlordiazepoxide HCl and 2.5 mg clidinium Br.

**Please consult complete prescribing information, a summary of which follows:**

**Indications:** Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

"Possibly" effective: as adjunctive therapy in the treatment of peptic ulcer and in the treatment of the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.

Final classification of the less-than-effective indications requires further investigation.

**Contraindications:** Glaucoma; prostatic hypertrophy, benign bladder neck obstruction; hypersensitivity to chlordiazepoxide HCl and/or clidinium Br.

**Warnings:** Caution patients about possible combined effects with alcohol and other CNS depressants, and against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Physical and psychological dependence rarely reported on recommended doses, but use caution in administering Librium® (chlordiazepoxide HCl) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions) reported following discontinuation of the drug.

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy. Advise patients to discuss therapy if they intend to or do become pregnant.**

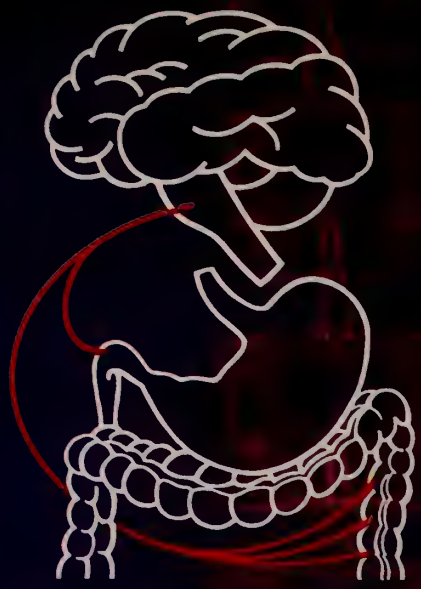
As with all anticholinergics, inhibition of lactation may occur.

**Precautions:** In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship not established.

**Adverse Reactions:** No side effects or manifestations not seen with either compound alone reported with Librax. When chlordiazepoxide HCl is used alone, drowsiness, ataxia, confusion may occur, especially in elderly and debilitated; avoidable in most cases by proper dosage adjustment, but also occasionally observed at lower dosage ranges. Syncope reported in a few instances. Also encountered: isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent, generally controlled with dosage reduction; changes in EEG patterns may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice, hepatic dysfunction reported occasionally with chlordiazepoxide HCl, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax typical of anticholinergic agents, *i.e.*, dryness of mouth, blurring of vision, urinary hesitancy, constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.

ROCHE

Roche Products Inc.
Manati, Puerto Rico 00701



## In treating certain G.I. disorders...

# Enhance your therapeutic expectation with the triple benefits of

Adjunctive

# Librax®

Each capsule contains 5 mg chlordiazepoxide HCl and 2.5 mg clidinium Br.

## antianxiety/antisecretory/antispasmodic

Librax is unique among G.I. medications in providing the specific antianxiety action of LIBRIUM® (chlordiazepoxide HCl) as well as the potent antisecretory and antispasmodic actions of QUARZAN® (clidinium Br) for adjunctive therapy of irritable bowel syndrome* and duodenal ulcer.*

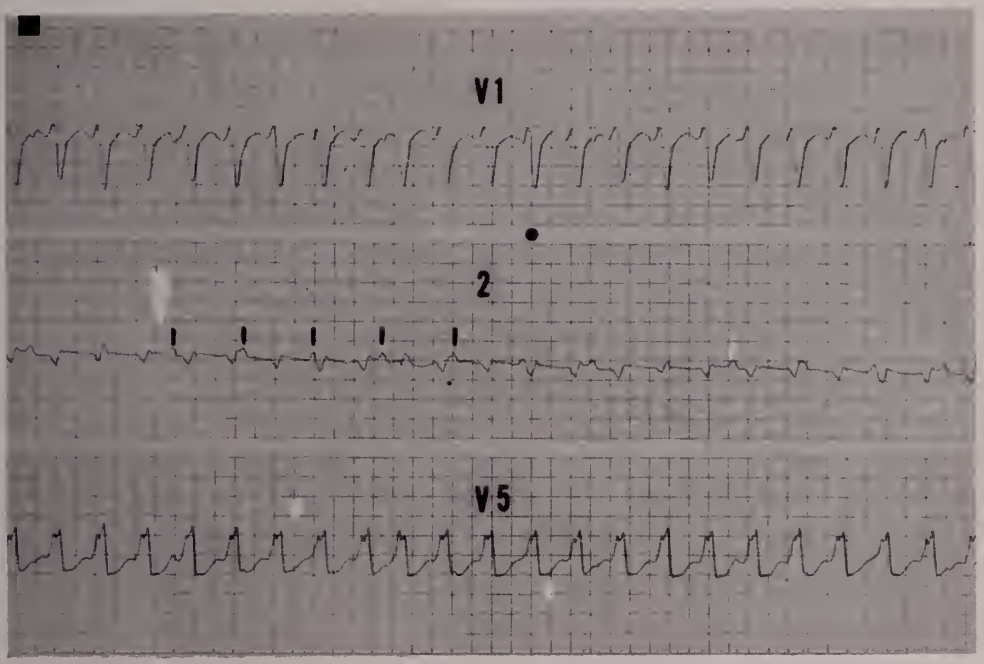
ROCHE

*Librax has been evaluated as possibly effective for this indication.
Please see brief summary of prescribing information on preceding page.

# ekg of the month

John F. Moran, M.S., M.D., David L. Fishman, M.D.,
Patrick J. Scanlon, M.D., Sarah A. Johnson, M.D.,
John R. Tobin, M.S., M.D., and Rolf M. Gunnar, M.S., M.D.
Section of Cardiology, Department of Medicine,
Loyola University Stritch School of Medicine

*This patient is a 67-year-old man who was in good health until he sustained an acute inferior wall myocardial infarction. He made an uneventful recovery from this myocardial infarction. However, during the subsequent twelve months, he was hospitalized four times for palpitations and mild congestive heart failure. His complaints were palpitations, fatigue and some dyspnea. Each time his physical examination was significant for a normal blood pressure, a tachycardia of 140 beats per minute, a gallop rhythm and bibasilar rales on pulmonary examination. The simultaneous $V_1$-2-$V_5$ rhythm strip electrocardiogram shown occurred on his most recent admission. Physical examination was the same as on earlier hospitalizations. His blood pressure was 136/86 and the tachycardia was 136 beats per minute. Cardiac catheterization was considered on this admission.*




## *Questions:*

**1. The ECG shows:**

A. Atrial fibrillation with complete left bundle branch block.
B. Complete atrioventricular dissociation.
C. Ventricular tachycardia.
D. Atrial tachycardia with the Wolf-Parkinson-White syndrome.
E. Fasicular ventricular tachycardia.

**2. Which of the following treatments have been used for recurrent ventricular tachycardia?**

A. Direct current cardioversion.
B. Intravenous lidocaine
Procainamide
Quinidine
C. Beta adrenergic blockade (Propranolol)
Diphenylhydantoin (Dilantin), Disopyramide (Norpace)
D. Aritificial pacemakers, epicardial mapping open heart surgery.
E. All of the above.

*(Continued on page 107)*

# A New Vision of Catapres® (clonidine HCl)

# 20/20



## The first 20 days

- Catapres lowers blood pressure promptly.
- No contraindications.
- Some patients may have dry mouth, drowsiness, and sedation. Tell them that these tend to diminish with continued use.
- Giving the larger part of the divided dose at bedtime can help alleviate drowsiness and sedation

## The next 20 years*

- Lowered blood pressure.
- Little impotence, depression or postural hypotension.
- No fatal hepatotoxicity in over a decade of worldwide use.
- Broad therapeutic dosage range to keep step with changing dosage needs over the years.

*Tolerance may develop in some patients, necessitating a reevaluation of therapy.

For full details on adverse reactions, warnings, and precautions, see brief summary of the prescribing information on last page of this advertisement.



**Catapres** (clonidine HCl)
**For Step 2 in Hypertension**

# HYPERTENSION

# A New Vision of Catapres®

## (clonidine HCl)

Tablets of 0.1 and 0.2 mg




## What you do the first 20 days Can help him the next 20 years

**Catapres®**
**(clonidine hydrochloride)**
Tablets of 0.1 mg and 0.2 mg

**Indication:** The drug is indicated in the treatme hypertension. As an antihypertensive drug, Cat (clonidine hydrochloride) is mild to moderate i It may be employed in a general treatment prog with a diuretic and/or other antihypertensive ag as needed for proper patient response.

**Warnings:** Tolerance may develop in some pati necessitating a reevaluation of therapy.
*Usage in Pregnancy:* In view of embryotoxic fin animals, and since information on possible adv effects in pregnant women is limited to uncont clinical data, the drug is not recommended in w who are or may become pregnant unless the po benefits outweigh the potential risk to mother a
*Usage in Children:* No clinical experience is av with the use of Catapres (clonidine hydrochlori children.

**Precautions:** When discontinuing Catapres (clo hydrochloride), reduce the dose gradually over 4 days to avoid a possible rapid rise in blood p and associated subjective symptoms such as n ness, agitation, and headache. Patients should instructed not to discontinue therapy without c their physician. Rare instances of hypertensive lopathy and death have been recorded after ce of clonidine hydrochloride therapy. A causal re ship has not been established in these cases. been demonstrated that an excessive rise in blo sure, should it occur, can be reversed by resum of clonidine hydrochloride therapy or by intrave nous phentolamine. Patients who engage in po tially hazardous activities, such as operating m or driving, should be advised of the sedative ef This drug may enhance the CNS-depressive eff alcohol, barbiturates and other sedatives. Like agent lowering blood pressure, clonidine hydro should be used with caution in patients with se coronary insufficiency, recent myocardial infarc cerebrovascular disease or chronic renal failure

As an integral part of their overall long-term patients treated with Catapres (clonidine hydro should receive periodic eye examinations. Whil except for some dryness of the eyes, no drug-r abnormal ophthalmologic findings have been r with Catapres (clonidine hydrochloride), in sev studies the drug produced a dose-dependent in in the incidence and severity of spontaneously ring retinal degeneration in albino rats treated 6 months or longer.

**Adverse Reactions:** The most common reaction dry mouth, drowsiness and sedation. Constipat dizziness, headache, and fatigue have been re Generally these effects tend to diminish with c therapy. The following reactions have been ass with the drug, some of them rarely. (In some in an exact causal relationship has not been esta These include: Anorexia, malaise, nausea, vom parotid pain, mild transient abnormalities in liv tion tests; one report of possible drug-induced titis without icterus and hyperbilirubinemia in receiving clonidine hydrochloride, chlorthalido papaverine hydrochloride. Weight gain, transie tion of blood glucose, or serum creatine phosp congestive heart failure, Raynaud's phenomen dreams or nightmares, insomnia, other behavio changes, nervousness, restlessness, anxiety a depression. Also rash, angioneurotic edema, h urticaria, thinning of the hair, pruritus not asso with a rash, impotence, urinary retention, incre sensitivity to alcohol, dryness, itching or burni eyes, dryness of the nasal mucosa, pallor, gyn mastia, weakly positive Coombs' test, asympto electrocardiographic abnormalities manifested Wenckebach period or ventricular trigeminy.

**Overdosage:** Profound hypotension, weakness lence, diminished or absent reflexes and vomit lowed the accidental ingestion of Catapres (clo hydrochloride) by several children from 19 mon 5 years of age. Gastric lavage and administrati analeptic and vasopressor led to complete reco within 24 hours. Tolazoline in intravenous dose 10 mg at 30-minute intervals usually abolishes fects of Catapres (clonidine hydrochloride) ove

**How Supplied:** Catapres, brand of clonidine hy chloride, is available as 0.1 mg (tan) and 0.2 m (orange) oval, single-scored tablets in bottles and 1000.

For complete details, please see full prescri information.

Under license from Boehringer Ingelheim G

Boehringer Ingelheim Ltd
Ridgefield, CT. 06877



# the view box

Leon Love, M.D./Chairman/Department of Radiology
Loyola University Stritch School of Medicine

By Richard A. Cooper, M.D., Assistant Professor of Radiology
Loyola University Medical Center, Maywood

*The patient is a 51-year-old male who came into the emergency room complaining of left shoulder pain of two weeks duration.*



**Figure 1**
**Left shoulder. Internal rotation.**

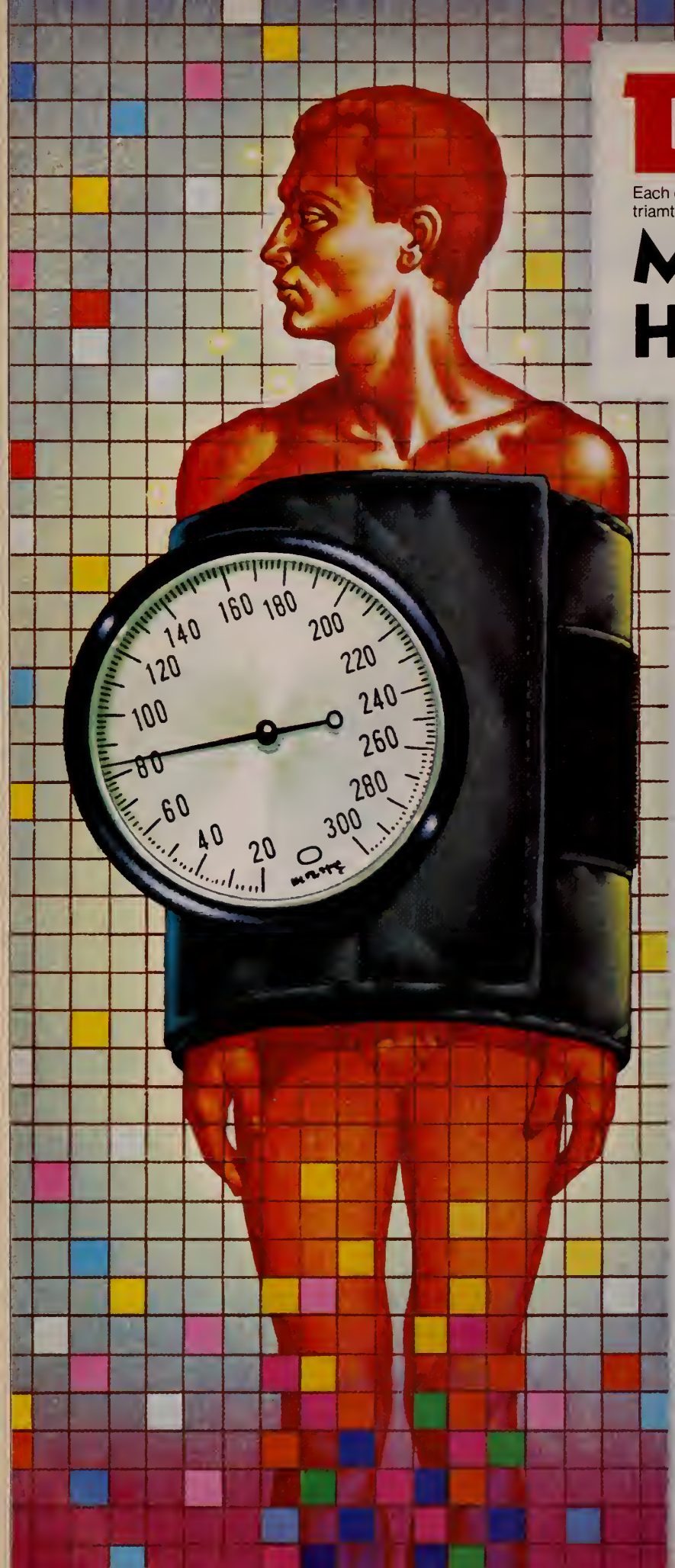


**Figure 2**
**Left shoulder. External rotation.**

## What is your diagnosis?

1. Posterior dislocation
2. Fracture
3. Anterior dislocation
4. None of the above

*(Continued on page 101)*




# Dyazide

Each capsule contains 50 mg. of Dyrenium® (brand of triamterene) and 25 mg. of hydrochlorothiazide.

# Makes Sense in Hypertension*

**Before prescribing, see complete prescribing information in SK&F Co. literature or *PDR*. A brief summary follows:**

* **Warning**
This drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual. If this combination represents the dosage so determined, its use may be more convenient in patient management. Treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

**Contraindications:** Further use in anuria, progressive renal or hepatic dysfunction, hyperkalemia. Pre-existin elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs.

**Warnings: Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired.** If supplementary potassium is needed, potassium tablets shoul not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely i the severely ill, with urine volume less than one liter/da the elderly and diabetics with suspected or confirmed renal insufficiency. Periodically, serum K+ levels shoul be determined. If hyperkalemia develops, substitute a thiazide alone, restrict K+ intake. **Associated widened QRS complex or arrhythmia requires prompt additiona therapy.** Thiazides cross the placental barrier and appea in cord blood. Use in pregnancy requires weighing anticipated benefits against possible hazards, includin fetal or neonatal jaundice, thrombocytopenia, other adverse reactions seen in adults. Thiazides appear an triamterene may appear in breast milk. If their use is essential, the patient should stop nursing. Adequate information on use in children is not available.

**Precautions:** Do periodic serum electrolyte determinations (particularly important in patients vomiting exces sively or receiving parenteral fluids). Periodic BUN an serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Watch for sign of impending coma in severe liver disease. If spironolactone is used concomitantly, determine serum K+ frequently; both can cause K+ retention and elevated serum K+. Two deaths have been reported with such concomitant therapy (in one, recommended dosage wa exceeded, in the other serum electrolytes were not properly monitored). Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, throm bocytopenia, agranulocytosis, and aplastic anemia hav been reported with thiazides. Triamterene is a weak fol acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effect may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. The following may occur transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserv with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine.

**Adverse Reactions:** Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis, rash, urticari photosensitivity, purpura, other dermatological conditions; nausea and vomiting, diarrhea, constipation, othe gastrointestinal disturbances. Necrotizing vasculitis. paresthesias, icterus, pancreatitis, xanthopsia and, rare allergic pneumonitis have occurred with thiazides alon

**Supplied:** Bottles of 100 and 1000 capsules; Single Un Packages of 100 (intended for institutional use only)

**SK&F CO.**
a SmithKline company

Carolina, P.R. 00630

Blue Cross®
Blue Shield®

# REPORT FOR *Illinois Physicians*

## Announcement on PAT Program and Ambulatory Surgery

An announcement urging the development or further implementation of two cost-effective benefit programs—Pre-Admission Testing for surgical patients (PAT) and Ambulatory Surgery when procedures are appropriate—has been mailed to hospital Administrators and Chiefs of Staff by the Illinois Blue Cross and Blue Shield Plan.

Over the co-signatures of Plan officers Richard C. Shaw, M.D., Vice President and Medical Director, and Mr. Robert S. Petersen, Senior Vice President, Provider Affairs, the announcement states:

"Two benefits pioneered by hospitals and their medical staffs and Blue Cross and Blue Shield are receiving increased attention as examples of programs that can ensure quality care while being cost effective. These programs are Pre-Admission Testing for surgical patients and Ambulatory Surgery.

"Many hospitals have such programs; unfortunately, not all; and those that are available are often not used as frequently as they could be.

"We *urge* you and your colleagues to take a new look at these programs; develop them if they do not now exist in your hospital; and see if there aren't opportunities to increase their utilization, if they do exist.

"We at Blue Cross-Blue Shield will also be looking at the programs by monitoring utilization to identify services which could have been appropriately carried out in Ambulatory Surgical settings or on a Pre-Admission Testing basis. We will review claims with you, when our monitoring indicates cases in which there may have been potential savings by utilizing one of these programs," the announcement emphasized.

As guidelines for the two programs, the announcement stated that the Medical Department has prepared a list of surgical procedures which often can be performed on an Ambulatory basis, and a similar list of elective surgical procedures for which Pre-Admission Testing is usually appropriate. Copies of the lists were enclosed with the announcement.

The announcement concluded with the statement that further information and assistance on establishing programs or expanding their utilization will be available by contacting either the Medical or Provider Affairs Department, Blue Cross and Blue Shield, 233 North Michigan Ave., Chicago, Illinois 60601.

## Supplement to Medical Assistants' Handbook to Be Distributed

The Supplement to the Second Edition of Blue Shield's Medical Assistants' Handbook has been completed and single copies will be mailed to physicians' offices by the Illinois Blue Cross and Blue Shield Plan. Mailing is expected to be completed by August 31.

The Supplement was prepared by the Professional Relations Department of the Plan to serve as an interim guide for medical assistants until the Third Edition of the Handbook is published.

It contains new information on several Blue Shield topics, and revises certain information in the Medical Assistants' Handbook, Second Edition, which was distributed to medical assistants in June, 1976.

The new 50-page publication reviews instructions on the proper completion of service reports, with special attention given to the new Blue Shield Physician's Service Report and Radiology Service Report forms. It also includes changes in reporting anesthesia services; certain changes in coverages for special groups; information on contacting our Professional Relations Representatives; Outpatient Emergency Care; and a new Directory of Blue Shield Plans.

An entire section of the Supplement illustrates the proper completion of service reports for a number of specific procedures including: surgery, services of a surgical assistant, fracture care, medical care, consultation, anesthesia, diagnostic X-ray, radiation therapy, psychiatric care, laboratory services and intensive medical care.

Explanations are given on special coverages including Supplemental Major Medical and Comprehensive Major Medical.

Changes in benefits for certain special groups are summarized, including: the Illinois Health Improvement Association; Bell Telephone; the Motor Groups; Federal Employees Program, United Mine Workers of America and State of Illinois Employees.

## Medicare Home Health Coverage

Medicare covers certain services rendered to homebound patients by Medicare-certified Home Health Agencies when the services are ordered by the physician. Medicare provides for up to 100 visits per benefit period under Part A, and up to 100 visits per calendar year under Part B, when the services being rendered meet home health coverage criteria.

The services which would qualify for coverage are intermittent skilled nursing care, skilled physical therapy, and skilled speech therapy. In addition, when any of these three services are being rendered, Medicare may also cover occupational therapy, services of home health aides, medical social services, and medical supplies and equipment.

### Conditions to be Met

Even though a person is entitled to Medicare, there are several conditions that must be met before home health services are covered. These are:

1. The patient must be confined to his/her home;
2. The services must be medically reasonable and necessary for the treatment of an illness or injury;
3. There must be a need for at least one skilled service; and,
4. The services must be rendered on an intermittent basis—as least once every sixty (60) days.

Part A Hospital Insurance will pay 100% of any and all home health care services, including medical supplies and the rental of equipment, providing a patient meets the three day prior qualifying hospital stay requirement, and the attending physician puts the orders and plan of treatment in writing within 14 days of discharge from the hospital.

Part B Medical Insurance will pay 100% of any and all services, including medical supplies and the rental of equipment, after the patient has met the current Part B deductible amount and providing the attending physician has the plan of treatment in writing prior to the Agency's submission of the initial Medicare claim.

Future articles will provide further details on covered home health care.

## Changes in Participation and Certification of Laboratory Procedures

Notices were received from the Medicare Bureau of the following changes in participation and certification of procedures of laboratories in the Medicare program:

**Relocation:**

Rhodes Medical Laboratory, Inc. (Provider Number 14-8344) is now located at 1420 North Milwaukee Ave., Chicago, Illinois 60622.

**Changes in Approved Specialties or Subspecialties:**

LaSalle Scientific Medical Laboratory, 914 West Diversey Parkway, Chicago, Illinois 60614 (Provider Number 14-8307) is no longer approved to perform Procedure 710-EKG Services, effective August 1, 1978. The laboratory is still approved to perform Procedures 110-Bacteriology; 200-Serology; 130-Parasitology; 300-Chemistry; 400-Hematology; 510-Blood Group and Rh and 520-Rh Titers; 610-Tissue and 630-Diagnostic Cytology.

Cicero Lake Laboratories, Inc., 4801 West Lake Street, Chicago, Illinois 60644 (Provider Number 14-8302) is no longer approved to perform Procedure 710-EKG Services, effective August 1, 1978. The laboratory is approved to perform Procedures 110-Bacteriology; 200-Serology; 310-Routine Chemistry; 320-Clinical Microscopy; 400-Hematology; 510-Blood Group and Rh; 630-Diagnostic Cytology.

Alpha Medical Laboratories, Inc., 7110 West 127th Street, Palos Heights, Illinois (Provider Number 14-8222) is no longer approved to perform Procedure 630-Diagnostic Cytology, effective August 1, 1978. The laboratory is approved to perform Procedures 100-Bacteriology; 200-Serology; 400-Hematology; 310-Routine Chemistry; 320-Clinical Microscopy; 710-EKG Services.

Kendon Medical Laboratory, Inc., 8625 South Cicero Ave., Chicago, Illinois 60652 (Provider Number 14-8052) is no longer approved to perform Procedure 330-Chemistry Other, effective August 1, 1978. The laboratory is approved to perform Procedures 110-Bacteriology; 300-Chemistry Routine; 200-Serology; 320-Clinical Microscopy; 400-Hematology; 710-EKG Services.

Avenue Medical Laboratory, 16234 St. Louis Ave., Chicago, Illinois 60743 (Provider Number 14-8050) is no longer approved to perform Procedure 120-Mycology, effective August 1, 1978. The laboratory is approved to perform Procedures 110-Bacteriology; 130-Parasitology; 200-Serology; 300-Chemistry; 400-Hematology; 510-Blood Group and Rh; 710-EKG Services.

Northbrook Community Laboratories, Inc., 1775 Walters Ave., Northbrook, Illinois 60002 (Provider Number 14-8023) is no longer approved to perform Procedure 330-Chemistry-Other, effective August 1, 1978. The laboratory is approved to perform Procedures 110-Bacteriology; 130-Parasitology; 200-Serology; 400-Hematology; 710-EKG Services.

*(This report is a service to the physicians of Illinois)*



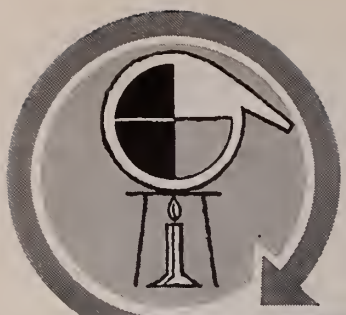

# Jobst®
# Venous Pressure Gradient® Supports

These measured, custom-made therapeutic elastic supports have carried the Jobst name to the four corners of the world. Prescription only, the supports can be engineered with counterpressures of 25, 30, 40 or 50 mm.Hg at the ankle, decreasing proximally along the venous pressure gradient. They are available in knee-length, full-leg, waist-height and lymphedema sleeve styles. The waist-height Jobst Pregnancy Leotard deserves special mention because each one is custom made with an expandable panel according to the patient's own measurements.

**Contact your local Jobst Service Center for complete details.**

## JOBST CHICAGO SERVICE CENTER

**Chicago, Illinois 60602**
Suite 2101, Pittsfield Bldg.
55 E. Washington Street
312/346-0446



# new pharmaceutical specialties

By Paul Dehaen

For detailed information regarding indications, dosage, contraindications and adverse reactions, refer to the manufacturer's package insert or brochure.

**New Single Drugs**—Drugs not previously known, including new salts.

**Duplicate Single Drugs**—Drugs marketed by more than one manufacturer.

**Combination Products**—Drugs consisting of two or more active ingredients.

**New Dosage Forms**—Of a previously introduced product.

**The following new drugs have been marketed:**

## COMBINATION PRODUCTS

**ROBITUSSIN-DAC**

| | |
|---|---|
| Manufacturer: | A. H. Robins Company |
| Composition: | *5 ml contains* |
| | Guaifenesin 100 mg |
| | Pseudoephedrine HCl 30 mg |
| | Codeine Phosphate 10 mg |
| | Alcohol 1.4% |
| Indications: | Nasal congestion and cough |
| Dosage: | One or two teaspoonful qid |
| Supplied: | Bottle, pint |

**ANDRESTRAC 2-10** Androgen/Estrogen Comb. Rx

| | |
|---|---|
| Manufacturer: | The Central Pharmacal Co. |
| Composition: | *Each ml* |
| | Testosterone 10 mg |
| | Estrone 2 mg |
| | Sod. Carboxymetyl-cellulose 2 mg |
| | Methylcellulose 0.2 mg |
| | Providone 0.2 mg |
| | Dioctyl sod. sulfosuccinate 0.15 mg |
| Indications: | Postpartum breast engorgement |
| Dosage: | im, cyclic administration |
| Supplied: | Multiple dose vial, 10 ml |

**SK-65 APAP** Non-narcotic analgesic Rx

| | |
|---|---|
| Manufacturer: | Smith Kline & French Laboratories |
| Composition: | Propoxyphene HCl 65 mg |
| | Acetaminophen 650 mg |
| Indications: | Relief of mild to moderate pain |
| Dosage: | One tablet every four hours |
| Supplied: | Tablets |

**DEMI-REGROTON** Hypotensive Rx

| | |
|---|---|
| Manufacturer: | USV Laboratories |
| Composition: | Chlorthalidone 25 mg |
| | Reserpine 0.125 mg |
| Indications: | Hypertension |
| Contraindication: | Mental depression, severe renal and hepatic diseases |
| Dosage: | Titrate individually, usual dose 1 tablet daily |
| Supplied: | Tablets |

**MOBIGESIC** Analgesic o.t.c.

| | |
|---|---|
| Manufacturer: | B. F. Ascher & Co., Inc. |
| Composition: | Magnesium salycylate 300 mg |
| | Phenyltoloxamine citrate 30 mg |
| Indications: | Pain associated with various conditions |
| Dosage: | Depending on painful condition |
| Supplied: | Tablets |

**SK-APAP With Codeine** Narcotic Analgesic Rx

| | |
|---|---|
| Manufacturer: | Smith Kline & French Laboratories |
| Composition: | Acetaminophen 325 mg |
| | Codeine 15, 30 and 60 mg |
| Indication: | Mild to moderate pain |
| Dosage: | Adjust to severity of pain |
| | Usual dose 1 to 2 tablets every four hours |
| Supplied: | Tablets |

**TRIAMINICIN ALLERGY** Antihistamine Cold Prep. o.t.c.

| | |
|---|---|
| Manufacturer: | Dorsey Laboratories |
| Composition: | Phenylpropanolamine HCl 37.5 mg |
| | Chlorpheniramine maleate 4.0 mg |
| Indications: | Temporary relief of nasal decongestion caused by allergy |
| Dosage: | Depending on patient's response |
| Supplied: | Tablets |

## NEW DOSAGE FORMS

**ORNADE 2** Nasal Decongestant o.t.c

| | |
|---|---|
| Manufacturer: | Smith Kline & French Laboratories |
| Composition: | Phenylpropanolamine HCl |
| | Chlorpheniramine maleate |
| Indications: | Relief of common cold |
| Dosage: | Children: 1 teaspoonful q.i.d. for ages 6 to 12 |
| | ½ teaspoonful q.i.d. for ages 2 to 6 |
| | Adults: 2 teaspoonfuls q.i.d. |
| Supplied: | Bottles, 4 oz |

# Obituaries

°°Abrahams, Samuel, Chicago, died June 16, at the age of 80. He was a 1923 graduate of the University of Illinois and has held a position on the medical staff of Northwestern Memorial Hospital for many years. Dr. Abrahams was a co-founder of the Multiple Sclerosis Foundation of Chicago.

°Brown, Amos Jerome, Chicago, died July 7, at the age of 57. He was a 1943 graduate of Northwestern University. Dr. Brown was the associate general medical director for the Western Electric Company and Michael Reese Medical Center as well as a member of several ISMS committees. He also served as chairman of the American Occupational Medical Assn. Committee on Alcohol and Drug Abuse.

°Green, R. Gregory, Rockford, died July 11, at the age of 64. He was a 1942 graduate of St. Louis University. Dr. Green was a past president of the Winnebago County Medical Society and of the Central States Industrial Medical Society.

°°Greenburg, Ira E., Florida, died June 9, at the age of 91. A 1910 graduate of Northwestern University, Dr. Greenburg had been a former secretary of the Englewood Hospital staff.

Littner, Michael M., Chicago, died June 30, 1978.

Moran, Clement J., Elmhurst, died April 25, at the age of 77. Dr. Moran was a staff physician and surgeon for 20 years at Hines VA Hospital.

°°Pickett, William J., Chicago, died April 22, at the age of 85. Dr. Pickett was a 1916 graduate and staff physician at Loyola University Medical School. He was also affiliated with Cook County Hospital where he taught surgery and held a staff position.

Plank, Joseph Raymond, Marion, died May 2, at the age of 73.

°Schlicksup, Edward P., Peoria, died July 3, at the age of 59. He was a 1946 graduate of the Stritch School of Medicine. Dr. Schlicksup was chief of urology at St. Francis Hospital.

°°Schmitz, Henry L., Florida, died June 27, at the age of 80. He was a 1926 graduate of Harvard Medical School. Before his retirement Dr. Schmitz was affiliated with Mercy Hospital and served as professor of medicine at Loyola University. He was also a fellow of the American College of Physicians.

Schwartz, Martin L., California, died July 6, at the age of 68. He was a graduate and later a trustee of the Chicago Medical School. Dr. Schwartz was a member of the staff at Michael Reese Hospital and director of the Abraham Levenson Foundation for mentally retarded children.

°Shay, Sujint S., Peoria, died June 19, at the age of 39. Dr. Shay was a 1964 graduate of Chiengmai Medical School, Thailand. He was a clinical professor of medicine at the Peoria School of Medicine and assistant medical director for cardiac care at Methodist Hospital of Central Illinois.

°Stearn, Anne M., Elgin, died July 1, at the age of 38. Dr. Stearn was a 1964 graduate of Cornell University.

°Stearn, Burton, Elgin, died July 1, at the age of 43. He was a 1962 graduate of Northwestern University.
Drs. Anne and Burton Stearn who, shared a career in medicine, both specialized in otolaryngology. The Stearns' deaths resulted from a tragic airplane crash.

°°Stevenson, Edgar McLean, Bloomington, died July 8, at the age of 80. Dr. Stevenson was a 1923 University of Michigan graduate. During his career as a physician he received many awards, including the Spirit of McLean award and the Edgar Stevenson Hall at the Illinois Wesleyan University, which was dedicated in 1965. Dr. Stevenson was a former president of the McLean County Medical Society and a staff member at Brokaw Menonite and St. Joseph's Hospital Medical Center.

°Sokolowski, Joseph F., Chicago, died July 19, at the age of 76. He was a 1929 graduate of the Stritch School of Medicine.

Vinci, Anthony J., Chicago, died April 19, at the age of 64.

Winston, W. Maurice, Phoenix, died May 30, at the age of 80. Dr. Winston was a practicing physician in Chicago Heights and Harvey.

*°Indicates ISMS member.*
*°°Indicates member of the ISMS Fifty Year Club.*


# CHIEF PHYSICIAN

Full time position with major South Chicago industrial concern, located conveniently to city or south suburban living.

Complete in-plant facilities with nearby consultative and hospital services available.

In addition to attractive compensation, this position carries an excellent corporate benefits package.

Please reply with curriculum vitae and/or professional history to Box 932, IMJ, 55 E. Monroe, Suite 3510, 60603.

An Equal Opportunity Employer M/F




# IN THE ILLINOIS AREA, STAPH RESISTANCE HAS NOW REACHED 79%.*

*resistance to penicillin G among community-acquired staph infections. Data on file, Bristol Laboratories.

## WHEN YOU CAN'T RULE OUT STAPH, CONSIDEI

# TEGOPEN®
# (cloxacillin sodium)

## ..."THE PENICILLIN OF TODAY"

- Effective against nonpenicillinase-producing staphylococci, beta-hemolytic streptococci, and pneumococci.†

†NOTE: The choice of Tegopen should take into consideration the fact that it has been shown to be effective only in the treatment of infections caused by pneumococci, Group A beta-hemolytic streptococci, and penicillin G-resistant and penicillin G-sensitive staphylococci. If the bacteriology report later indicates that the infection is due to an organism other than a penicillin G-resistant staphylococcus sensitive to cloxacillin sodium, the physician is advised to continue therapy with a drug other than cloxacillin sodium or any other penicillinase-resistant semisynthetic penicillin. The clinical significance of *in vitro* data is unknown.

- 10 times more active against strep than staph.
- Well absorbed from the G.I. tract.‡

‡Maximum absorption occurs when Tegopen is taken on an empty stomach, preferably 1-2 hrs. before meals.



Please see brief summary for prescribing information.

**Brief Summary of Prescribing Information**
**Combined TEGOPEN® (cloxacillin sodium)**
**Capsules and Oral Solution**
For complete information, consult Official Package Circular. (12) TEGOPEN 9/11/75

**Indications:** Although the principal indication for cloxacillin sodium is in the treatment of infections due to penicillinase-producing staphylococci, it may be used to initiate therapy in such patients in whom a staphylococcal infection is suspected. (See Important Note below.)

Bacteriologic studies to determine the causative organisms and their sensitivity to cloxacillin sodium should be performed.

**Important Note:** When it is judged necessary that treatment be initiated before definitive culture and sensitivity results are known, the choice of cloxacillin sodium should take into consideration the fact that it has been shown to be effective only in the treatment of infections caused by pneumococci, Group A beta-hemolytic streptococci, and penicillin G-resistant and penicillin G-sensitive staphylococci. If the bacteriology report later indicates the infection is due to an organism other than a penicillin G-resistant staphylococcus sensitive to cloxacillin sodium, the physician is advised to continue therapy with a drug other than cloxacillin sodium or any other penicillinase-resistant semi-synthetic penicillin.

Recent studies have reported that the percentage of staphylococcal isolates resistant to penicillin G outside the hospital is increasing, approximating the high percentage of resistant staphylococcal isolates found in the hospital. For this reason, it is recommended that a penicillinase-resistant penicillin be used as initial therapy for any suspected staphylococcal infection until culture and sensitivity results are known.

Cloxacillin sodium is a compound that acts through a mechanism similar to that of methicillin against penicillin G-resistant staphylococci. Strains of staphylococci resistant to methicillin have existed in nature and it is known that the number of these strains reported has been increasing. Such strains of staphylococci have been capable of producing serious disease, in some instances resulting in fatality. Because of this, there is concern that widespread use of the penicillinase-resistant penicillins may result in the appearance of an increasing number of staphylococcal strains which are resistant to these penicillins.

Methicillin-resistant strains are almost always resistant to all other penicillinase-resistant penicillins (cross-resistance with cephalosporin derivatives also occurs frequently). Resistance to any penicillinase-resistant penicillin should be interpreted as evidence of clinical resistance to all, in spite of the fact that minor variations in *in vitro* sensitivity may be encountered when more than one penicillinase-resistant penicillin is tested against the same strain of staphylococcus.

**Contraindications:** A history of a previous hypersensitivity reaction to any of the penicillins is a contraindication.

**Warning:** Serious and occasionally fatal hypersensitivity (anaphylactoid) reactions have been reported in patients on penicillin therapy. Although anaphylaxis is more frequent following parenteral therapy it has occurred in patients on oral penicillins. These reactions are more apt to occur in individuals with a history of sensitivity to multiple allergens.

There have been well documented reports of individuals with a history of penicillin hypersensitivity reactions who have experienced severe hypersensitivity reactions when treated with a cephalosporin. Before therapy with a penicillin, careful inquiry should be made concerning previous hypersensitivity reactions to penicillins, cephalosporins, and other allergens. If an allergic reaction occurs, the drug should be discontinued and the patient treated with the usual agents, e.g., pressor amines, antihistamines, and corticosteroids.

Safety for use in pregnancy has not been established.

**Precautions:** The possibility of the occurrence of superinfections with mycotic organisms or other pathogens should be kept in mind when using this compound, as with other antibiotics. If superinfection occurs during therapy, appropriate measures should be taken.

As with any potent drug, periodic assessment of organ system function, including renal, hepatic, and hematopoietic, should be made during long-term therapy.

**Adverse Reactions:** Gastrointestinal disturbances, such as nausea, epigastric discomfort, flatulence, and loose stools, have been noted by some patients. Mildly elevated SGOT levels (less than 100 units) have been reported in a few patients for whom pretherapeutic determinations were not made. Skin rashes and allergic symptoms, including wheezing and sneezing, have occasionally been encountered. Eosinophilia, with or without overt allergic manifestations, has been noted in some patients during therapy.

**Usual Dosage:** Adults: 250 mg. q.6h.

Children: 50 mg./Kg./day in equally divided doses q.6h. Children weighing more than 20 Kg. should be given the adult dose. Administer on empty stomach for maximum absorption.

*N.B.:* INFECTIONS CAUSED BY GROUP A BETA-HEMOLYTIC STREPTOCOCCI SHOULD BE TREATED FOR AT LEAST 10 DAYS TO HELP PREVENT THE OCCURRENCE OF ACUTE RHEUMATIC FEVER OR ACUTE GLOMERULONEPHRITIS.

**Supplied:** Capsules—250 mg. in bottles of 100, 500 mg. in bottles of 100. Oral Solution—125 mg./5 ml. in 100 ml. and 200 ml. bottles.

BRISTOL®
BRISTOL LABORATORIES
Division of Bristol-Myers Company
Syracuse, New York 13201

# *Ask the Consultant*

*"Ask the Consultant" is a new IMJ feature. Readers are encouraged to write with clinical questions for which they have not been able to find solutions. The questions will be forwarded to the IMJ Editorial Board. Board members will provide responses, or find specialists to find solutions. Interested readers are asked to write IMJ, 55 E. Monroe, Suite 3510, Chicago 60603. Please specify that your question is for the "Ask the Consultant" column.*

**What can be done to reduce the risks in non-cardiac surgery in patients with coronary artery disease?**

In spite of much improvement in anesthesia and surgery in recent years and the improvements in post-operative care, morbidity and mortality remain inordinately high in non-cardiac surgical procedures for patients with coronary artery disease as compared to patients of similar age without heart disease. These patients with a damaged cardiovascular system are prone to more risk with any surgical procedure. The hypotension, hypoxemia, infection and thrombo-embolic problems often associated with surgery are especially hazardous in an already damaged heart.

Realizing all this, careful monitoring of cardiac and hemodynamic status both during and after surgery to avoid hypotension, volume overload and maintain IV fluid requirements with stable cardiac rhythm, will permit surgery to be done without undo risk.

Avoid digitalis when there is no congestive failure or atrial tachycardia in the operative period. Usually a temporary pacemaker may not be needed and propranolol may gradually be discontinued. If cardiac surgical expertise is available, sometimes bypass surgery would be desirable before the non-cardiac surgery is done. (For more information, see: Hills L. David, Cohn Peter F.: "Noncardiac Surgery in Patients With Coronary Artery Disease," *Arch. Internal Med.*, 138:972, 1978.)

# contains no aspirin

tablets

# Darvocet-N® 100 ℞

100 mg. Darvon-N® (propoxyphene napsylate)
650 mg. acetaminophen

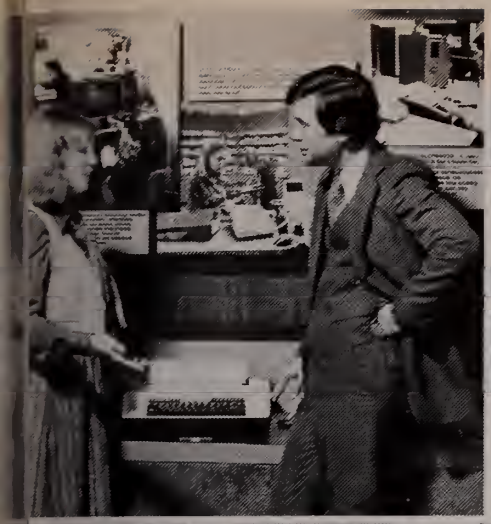



Lilly

700565

*Additional information available to the profession on request from Eli Lilly and Company Indianapolis, Indiana 46206*

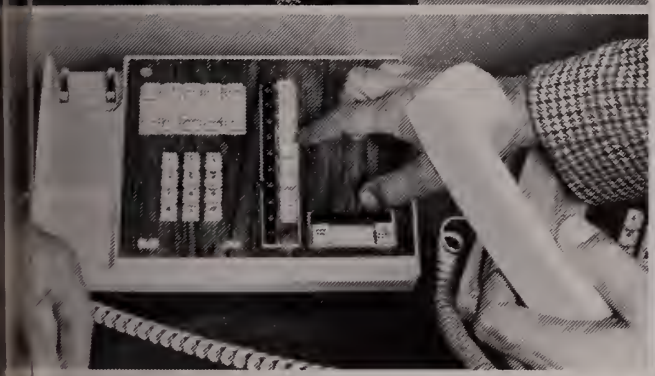
Eli Lilly and Company, Inc.
Carolina, Puerto Rico 00630













# A new place where businesses can get help solving their communications problems.

's a unique facility designed cially for the decision maker who ts a communications solution saves dollars and makes sense. ther you make decisions for your independent business. Or for a ion of a larger corporation. e start at the beginning. With your nunications problems. You talk your situation with a professional has specialized in business nunications.

ien we suggest appropriate ions.

e're fully equipped to give you s-on demonstrations of Bell em equipment. From phones that




*COMMUNICATIONS PLANNING CENTER*
*155 N. Wacker Dr. 800-972-2117*
*Mon.-Fri. 8:30 A.M.-5:00 P.M.*

can solve the problem of missing calls from important customers. To up-to-the-minute Bell data terminal equipment.

Then we work together to design a system specifically customized to your business needs. Often you can arrange the installation details on the spot.

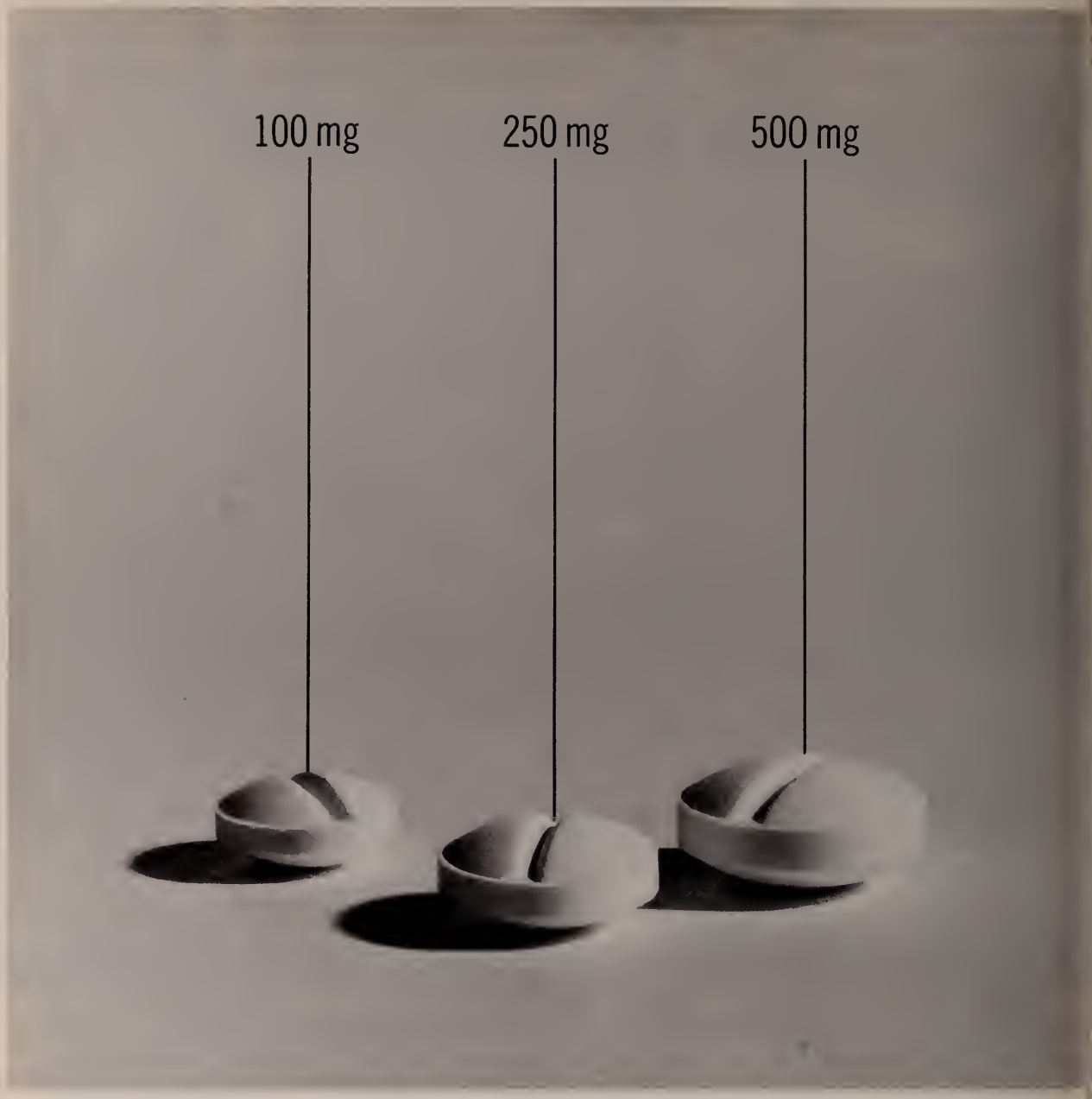
At 155 N. Wacker Drive, it's close to the Loop. And close to the commuter train stations.

So stop by. Or call ahead, toll-free, 800-972-2117. Give us a chance to have a recommendation waiting for you when you stop by.

Solving communications problems isn't really that difficult.

**The System is the Solution.**

Illinois Bell




# Tolinase®
## tolazamide, Upjohn

Please contact your Upjohn representative for additional product information.

Upjohn

J-5695-6

©1977 THE UPJOHN COMPANY

IMJ
*Illinois Medical Journal*
Vol. 154, No. 2, August, 1978

# Carcinoma Arising In a Thyroglossal Duct Cyst

By Phillip L. Cacioppo, M.D. and Mohin T. Samaraweera, M.D./
Evanston and Chicago

*Primary carcinoma arising in a thyroglossal duct is rare, but this case again demonstrates the necessity for excision of all thyroglossal duct remnants. The differentiation of midline and lateral ectopic thyroid tissue is discussed.*

Although rare, carcinoma arising in the thyroid tissue present in a thyroglossal duct cyst has been long recognized. The true pathology is seldom diagnosed preoperatively. It is seen in a female to male ratio of 2:1.[1] Most are papillary lesions, other histologies have been reported.[2]

*Case Report:* A 24-year-old white female presented with the history of a midline upper neck mass increasing in size over the seven months prior to admission. No pain or dysphagia was associated with the mass. The clinical impression was that of a thyroglossal duct cyst. Pre-operative $I^{131}$ radioisotope thyroid scan and function studies ($T_3$ and $T_4$) were normal. At exploration the mass appeared cystic and lobulated, in the classic location for a thyroglossal duct cyst. There was no attachment to the thyroid gland. An enlarged adjacent lymph node was hyperplastic without tumor, and a standard Sistrunk procedure was performed.[3] Grossly, the cyst was multiloculated and filled with yellow gelatinous material. The lining was smooth except for one focus of friable papillary material adjacent to the hyoid bone. Histologic diagnosis was that of mixed papillary and follicular adenocarcinoma, predominantly papillary, containing psammoma bodies with normal thyroid tissue present. (Fig-

PHILLIP CACIOPPO, M.D., is a clinical assistant professor of surgery affiliated with the Loyola University Stritch School of Medicine. Doctor Cacioppo is also an attending surgeon at St. Francis Hospital in Evanston and director of the blood flow laboratory at that institution. He is a board certified general surgeon.



MOHIN T. SAMARAWEERA, M.D., is a pathologist affiliated with Resurrection Hospital in Chicago. He is board certified in both anatomical and surgical pathology.

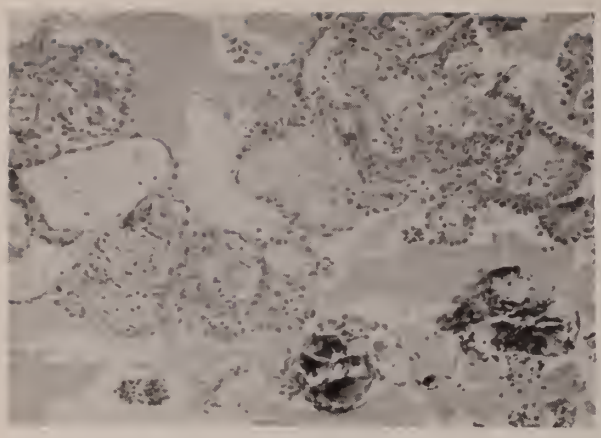


**Figure 1**

**Photomicrograph showing mixed papillary and follicular adenocarcinoma of thyroid tissue. Psammoma bodies are present.**



**Fjgure 2**

**Photomicrograph showing cystic component and normal thyroid tissue.**

ures 1 and 2) There was no extension through the cyst wall, which was lined by cuboidal epithelium.

## Discussion

The occurrence of carcinoma arising in a thyroglossal duct remnant has been shown to be one in 128 by Nachlas[4] and two in 130 by Choy.[5] Since thyroglossal duct cysts are unusual the finding of carcinoma is exceedingly rare. An excellent review of the entire subject by LiVolsi *et al.*,[6] found normal thyroid tissue in varying amounts up to 64%. Although lateral ectopic thyroid tissue is accepted as metastatic disease, midline ectopic thyroid is considered benign unless specific histologic evidence of malignancy is noted. Most carcinomas arising in median ectopic thyroid tissue are papillary adenocarcinoma.[1,2] Significant other histologies, however, including squamous cell carcinoma and mixed papillary and follicular carcinoma, have been included in 21% of cases reported by Bhagavan.[2]

Controversy has arisen only in distinguishing true ectopic thyroid tissue from metastatic cystic carcinoma. In the presence of normal thyroid tissue at the site of the lesion, it is reasonable to assume that carcinoma has arisen in ectopic tissue.[7]

## Management

The management of a carcinoma arising in a thyroglossal duct cyst is basically the Sistrunk procedure[3] with evaluation of the adjacent nodal tissue and of the thyroid gland with careful postoperative monitors for local recurrence. Presence of suspicious or positive nodes should be the criteria for nodal dissection. If the thyroid gland is normal to palpation and scan, it is generally felt that total thyroidectomy is not advised.[1,2,6] If the thyroid gland is abnormal, then the lesions must be treated as a primary thyroid neoplasm or at least a multicentric disease. Survival is excellent with this plan of management.[1,6] The care of this disease as in adenocarcinoma of the thyroid gland itself must be continued over a 20-year followup because of the natural history of adenocarcinoma originating in thyroid tissue.[8] ◄

## References


1. Jaques, D. A., Chambers, R. G., Oertel, J. E.: "Thyroglossal Tract Carcinoma," *Am. J. Surg.*, 120:439-446, 1970.
2. Bhagavan, B. S., Rai, O. R., Weinberg, T.: "Carcinoma of Thyroglossal Duct Cyst," *Surgery*, 67:281-292, 1970.
3. Sistrunk, W. E.: "Technique of Removal of Cysts and Sinuses of the Thyroglossal Duct," *Surg. Gynec. & Obst.*, 46:109, 1928.
4. Nachlas, N. E.: "Thyroglossal Duct Cysts," *Ann. Otol. Rhinol. Laryngol.*, 59:381, 1950.
5. Choy, F. J., Ward, R., Richardson, R.: "Carcinoma of the Thyroglossal Duct," *Am. J. Surg.* 108:361, 1964.
6. LiVolsi, V. A., Perzin, K. H., Savetsky, L.: "Carcinoma Arising in Median Ectopic Thyroid (Including Thyroglossal Duct Tissue," *Cancer*, 34:1303-1315, 1974.
7. Nuttall, F. Q.: "Cystic Metastases From Papillary Adenocarcinoma of the Thyroid with Comments Concerning Carcinoma Associated with Thyroglossal Remnants," *Am. J. Surg.*, 109:500-505, 1965.
8. Frazell, E. K., Foote, F. W., Jr.: "Papillary Carcinoma of the Thyroid," *Cancer*, 11:895, 1958.

# The University Medical School Reaching to the Community Physician

By Richard L. Byyny, M.D., Linda K. Gunzburger, M.S., Chase P. Kimball, M.D., Mark Siegler, M.D., and Alvin R. Tarlov, M.D./Chicago

*In our new era of health care planning and system implementation, the University of Chicago is establishing a regional network of community hospitals which provides a means by which continuing medical education is available to the practicing community physician. Based on a firm academic tradition, the Medical School has found it necessary to form relationships with community hospitals. These relationships not only provide learning programs for physicians but offer valuable learning experiences for medical students, interns, and residents. To obtain quality health care it is necessary to extend the education in medicine beyond the walls of the medical school. Through joint cooperation the university physician can aid the community physician in management of difficult cases and in referrals. However, the community physician is needed to provide the setting and guidance depicting primary and secondary community health care.*

This is a time when the attention of the nation and medicine in general is turning toward the organization of health resources in an effort to distribute these more efficaciously for the prevention, detection, and remediation of illness and disease. Academic centers geared to address themselves, their faculties and services to the technology of the biomedical revolution of the past quarter century may suddenly find themselves helplessly deficient in their wherewithal to face what are doubtless the major challenges of the next quarter century.

As the University of Chicago, similar to other major universities, emerges into this new era of health education, research, and service it finds its resources in most every respect woefully inadequate to help plan for and synthesize plans to accommodate itself to the changing social and consequent political and financial patterns of this medical evolution.

Academic medical centers will become increasingly involved in all levels of education and training. This will require simultaneous solutions to problems regarding the type of students appropriate for such careers, the setting in which they should be taught, the content of their education and training and the allocation of public and private resources to this enterprise. However, the critical component in this process will be the teachers. It is this group which must select future students, create model settings in

RICHARD L. BYYNY, M.D., is an internist currently affiliated with the University of Colorado Medical Center in Denver, where he is head of the division of general internal medicine and vice-chairman of the department of medicine. At this writing, Doctor Byyny was director of the section of general internal medicine at the University of Chicago.

LINDA K. GUNZBURGER, M.S., is an evaluator-educator, special track curriculum and coordinator of the division of continuing medical education at the Loyola University-Stritch School of Medicine. At this writing, Ms. Gunzburger was educational coordinator at the University of Chicago office of postgraduate medical education.

CHASE P. KIMBALL, M.D., is a professor of psychiatry and medicine in the University of Chicago division of biological sciences. Doctor Kimball specializes in psychosomatic medicine.

MARK SIEGLER, M.D., is an assistant professor at the University of Chicago department of medicine. Doctor Siegler is also a diplomat of the American Board of Internal Medicine.

ALVIN R. TARLOV, M.D., F.A.C.P., is chairman of the department of medicine ot the University of Chicago.

which they are to be taught, define a curriculum relevant to the needs of their patients, provide opportunities for continuing education and training which focus on improving the outcome of patient care, and assure that sufficient resources are available to carry out these tasks.[1]

It is within the frameworks of continuity and change that we believe many university medical schools in the 1970's share comon features, including abiding commitments to excellence in the care of patients, in the training of undergraduate and postgraduate students, and in the discovery of new information through basic and clinic research.[2] Thus, it is our hope that the experience at the University of Chicago will be helpful to other medical schools as they develop within their own unique settings an approach to a pressing need in medical education in the 1970's, the strengthening of training programs.

## The University of Chicago System—Background

A medical school at the University of Chicago was not established until 1927, although one had been proposed even before the university was founded in 1893. This 34-year delay between conception and realization allowed the developers of the medical school to create an institution whose organization incorporated major advances in American medical education and also reflected the philosophical orientation of the University of Chicago. The unique organizational features of the new medical school included a true university medical school; a true full-time, fully-salaried medical faculty; university ownership and management of a general hospital with both inpatient and outpatient facilities; a major commitment to research and the generation of new information within the context of patient care and clinical teaching and a belief in a functional division of labor within medical school departments.

This pattern of organization resulted in a remarkably effective system of medical education and practice, which lent itself easily to the introduction of innovations and change. Thus, for example, in 1928 the Department of Medicine at the University of Chicago incorporated the subspecialty system of practice, which antedated by two decades the national movement in this direction. Following World War II the existence of strong subspecialty sections within the department of medicine proved an ideal arrangement for capitalizing on the availability of government funds for research and training, and the system was further strengthened. These funds were usually dispensed through categorical institutes of the NIH, and categorical sections of a large department of medicine were able to compete with special effectiveness for these grants.

Forty years of experience with the subspecialty system has allowed the University of Chicago ample opportunity to appreciate the strengths and weaknesses of this system.[3]

## Community Hospitals Relationships

Three years ago, general internal medicine initiated relationships with several community hospitals to the south of the university for the purpose of assisting them in continuing medical education programs in their hospitals, as well as for the purpose of fostering referral of patients to the university hospital. This program has subsequently grown in scope to include many of the clinical departments and is now coordinated by a multi-departmental committee on community health affairs and hospitals appointed by the Dean. The educational programs in each of six community hospitals are coordinated by one member of the faculty from the university, five of whom are of the Department of Medicine, two of these from the section of general internal medicine.

Since 1972, we became interested in developing mutually beneficial relationships with hundreds of privately practicing physicians and their hospitals. The physicians, and their patients most accessible to us were to the south and southwest in a 30 mile hemicircle of the university. Contact was made through the hospitals where these physicians were privileged. Programs have been developed whereby we provide continuing education (lectures, grand rounds, clinical pathological conferences) for the medical staff *in* their hospital, and in turn the physicians use our staff and facilities for consultation and for direct transfer of patients requiring tertiary, or complicated, care.[4]

## Office of Postgraduate Medical Education

With funding from the National Fund for Medical Education, the University of Chicago was able to establish an Office of Postgraduate Medical Education in 1974 and begin to conceptualize an advanced training program in general internal medicine. The Office enables the synthesis and integration of all present post-

graduate activities and continuing education programs in health related services at the University of Chicago.

These programs serve to bolster the community hospitals' attempts to recruit younger staff members, but also keep general physicians abreast of contemporary developments in medicine, surgery, obstetrics-gynecology and psychology. The university departments have also established consultation activities at these hospitals.

The Office is also planning refinements in the educational program, particularly in the area of methodology. Utilizing a now basic methodological approach to the field of continuing medical education, each of our coordinators, with the assistance of our Department of Education, is attempting to determine the specific needs of the medical staff in each of these hospitals and to develop the objectives of the educational program based upon these.

The university has taken the initial steps necessary for implementing the Office of Postgraduate Medical Education. The educational program director brings expertise in educational methods to the content program that our consultants identify. Such an individual assists coordinators and consultants in selecting appropriate methods by which to convey content material. In addition, the director identifies those areas within a given hospital program where integration and synthesis could be achieved. As programs are developed at several hospitals, the director will identify in what ways individual hospital programs might be related to one another. For example, in the event that several hospitals develop family medicine residency programs, it is possible that part of the didactic course work in these programs might be given on the university campus.

The program director is responsible for the intramural continuing education program at the University of Chicago and is challenged to seek ways to relate these to the extramural programs. Similarly the director works with other programs coordinated by the Committee on Community Health Affairs and Hospitals, e.g., the cancer control program. The director is expected to devise methods of evaluating the educational and referral programs and to assist in whatever investigative activities the commitee might propose for evaluating health needs and resources in the area of a particular community hospital. The director inaugurates and/or participates in grant applications to private and public agencies with a view toward developing resources of the Office and in developing the advanced training program in General Internal Medicine.

### Advanced Training Program in General Internal Medicine

The section of general internal medicine has established a two-year advanced training program which is designed to prepare internists for positions in academic general internal medicine, or for positions as directors of medical education in community hospitals. Three years of training in internal medicine (internship plus two years of residency) is a prerequisite. The objectives of the training program include the definition and development of the skills of a general internist, the acquisition of skills and techniques of education, training in the methodology of evaluation research, and experience in the organization and utilization of biomedical information systems.

The development of outstanding clinical skills will be emphasized because we believe that the most effective general internal medicine educator will be one who is acknowledged by students and colleagues to be an exceptionally skillful physician. This program will not merely extend the existing residency program, but will concentrate in areas that are not well treated in the present residency. These special areas include training in the organization and management of more effective ambulatory internal medicine; the heretofore underemphasized skills and responsibilities required of a principal physician to solicit, coordinate and clinically evaluate the opinions and recomendations of multiple consultants in a complex medical situation and arrive at a wise course of action; a special awareness and knowledge of clinical pharmacology which would allow one to practice and teach a more precise and scientific therapeutics; the organization and direction of intensive care units; and experience in the special knowledge and techniques required for effective consultation on surgical patients.

The acquisition of the skills and techniques of education will be an important part of the advanced training program. The expertise of the Department of Education at the university will be enlisted to instruct the trainee on methods of planning, teaching, and evaluating programs in undergraduate, graduate and postgraduate education.

Instruction will be provided in the methodology of evaluation research and cost-benefit anal-

ysis, and its application to health-care systems and to quality-care assessment. The instruction in these areas will be provided by the School of Social Service Administration and the Center for Health Administration Studies of the Graduate School of Business, at the University of Chicago.

In cooperation with the School of Library Science, the trainees will gain experience in the planning, organization and management of libraries and biomedical information systems.

Finally, all trainees will be required to undertake independent investigation in one of the areas emphasized above. Some of the trainees may wish to pursue an advanced degree (either a Masters or a Doctorate) in one of the departments of the university affiliated with this program.[5]

## The Need for a Regional Approach

Primary medical training cannot adequately be incorporated only within its campus clinics, or in medically underserved areas without addressing the varying health concerns of inner-city and non-urban communities. While significant resources have been directed since the mid-1960's into inner-city areas, little substantive work has been accomplished in the smaller, non-urban communities. Concern is for programs that link non-urban area institutions with the resources of the university medical center. Coordination of urban and more distant non-urban institutions of necessity requires planning and resource allocations from a regional perspective.

The university considers that a) development of "communiversity" relationships will favorably support its on-campus teaching and research requirements for large, referral specialty patient populations, and b) provide off-campus opportunity for its faculty and students in the areas of health policy planning and research.[6]

## Conclusion

By our regionally reaching to the community physicians, their continuing education would be built into the character of their professional lives, and would become natural, a habit. They could assist in teaching our students and residents within their own practices, they might attend conferences, seminars, and courses at the University Hospital, and they would undoubtedly use our subspecialty consultation services and refer patients to the university for specialized care. The epidemiology and demography of illness in their setting may provide research opportunities for scientists at the university. ◄

### References


1. Chase Patterson Kimball, M.D.: "The Challenge of Medicine in the '70's: Health Care through Education." *JAMA*, Vol. 216, No. 13, 1971.
2. Daniel C. Tosteson, M.D.: "The Right to Know: Public Education for Health." *Journal of Medical Education*, Vol. 50, pages 117-123, 1975.
3. R. L. Byyny, M.D., M. Siegler, M.D. and A. R. Tarlov, M.D.: "Development of General Internal Medicine at the University of Chicago." To be published in *JAMA*.
4. Edward Rubenstein, M.D.: "Continuing Medical Education at Stanford: The Back-to-Medical School Program." *Journal of Medical Education*, Vol. 48, No. 10, pages 911-918, 1973.
5. John G. Freymann: The American Health Care System: Its Genesis and Trajectory. New York: Medcom, Inc., 1974.
6. "University of Chicago Regional Study Strengthening Medical Care through Institutional Development, Institutional Interrelations and Medical Education": a Proposal prepared by the Committee on Community Health Affairs and Hospitals, University of Chicago, Pritzker School of Medicine, June, 1975.



**COOK COUNTY**

**Graduate School of Medicine**

CONTINUING EDUCATION COURSES
STARTING DATES—1978

SPECIALTY REVIEW MEDICINE, CERTIFYING, August 6
SPECIALTY REVIEW ORTHOPAEDICS, August 25
ESSENTIALS OF ELECTROCARDIOGRAPHY, 5 days, September 18
EKG FOR ANESTHESIOLOGISTS, 5 days, September 18
SPECIALTY REVIEW DERMATOLOGY, 5 days, September 25
SPECIALTY REVIEW OBSTETRICS & GYNECOLOGY, September 25
CURRENT TOPICS IN INTERNAL MEDICINE, September 25
SEXUAL MEDICINE, 5 days, September 25
NEUROLOGY, PART II, CLINICAL, October 9
QUALITY ASSURANCE EVALUATION, 3 days, October 12
CLINICAL & LABORATORY DIAGNOSIS OF HEMORRHAGIC AND THROMBOTIC DISORDERS, 2 days, October 20
MANAGEMENT OF COMMON FRACTURES, 5 days, October 23
SPECIALTY REVIEW SURGERY, PART I, October 23
RECENT ADVANCES IN PSYCHIATRY, 5 days, October 23
RECERTIFICATION REVIEW IN OB-GYN, 5 days, October 30
RECENT ADVANCES IN NEUROLOGY, 5 days, November 13

*Information concerning numerous other continuation courses available upon request.*

**Address:**
**REGISTRAR, 707 South Wood Street,**
**Chicago, Ill. 60612**



# Seminars In Immunopathology and Oncology

Richard J. Ablin, Ph.D., Contributing Editor

# Immune Complexes and Human Disease

By Brian S. Andrews, BSc(Med) and Ronald Penny, M.D./Sydney, Australia

*This is the first of three parts in a special overview series for the "Seminars in Immunopathology and Oncology." In part one, Doctors Penny and Andrews delineate the historical background to immune complex research. Part two, exploring detection of immune complexes, will be published in the September* IMJ.

When a foreign, exogenous antigen enters the body, a specific binding protein (antibody) is formed to eliminate it. Under normal circumstances, the combination of antigen (Ag) with antibody (Ab) results in the formation of an immune complex (IC) which is rapidly cleared from serum and tissues by the phagocytic system. However, complexes sometimes continue to circulate, deposit on vascular basement membranes and result in an inflammatory reaction. In other situations, endogenous or auto-antigens are associated with formation of excessive quantities of Ab resulting in similar ICs and typified by systemic lupus erythematosus (SLE).

As IC formation represents a normal immune clearance mechanism for Ag, it is clear that circulating IC's only result in clinically overt disease under certain circumstances. If ICs are to be incriminated in the pathogenesis of a specific disease, certain ideal criteria should be established: (a) an Ag should be identified; (b) an IC containing both Ag and Ab should be demonstrated in serum and tissues; (c) the pathogenic nature of the circulating IC should be established, *e.g.*, ability to activate complement (C); and (d) the level of circulating ICs should parallel clinical disease activity.

Acute serum sickness represents the prototype of a human IC disease produced by an exogenous Ag. It was first described in 1905 by von Pirquet and Schick[1] who proposed the basic underlying mechanisms. These were subsequently validated by both Germuth[2] and Dixon and colleagues.[3] Rabbits were immunized with a single large injection of bovine serum albumin ("one shot serum sickness") and at the onset of Ab production developed an acute serum sickness reaction.



BRIAN S. ANDREWS, BSc(Med), MB, BS, FRACP, is on assistant professor of medicine affiliated with the University of Virginia. He graduated MB BS, from the University of Sydney Medical School in Sydney Australia. Doctor Andrews is a fellow of the Royal Australian College of Physicians.



RONALD PENNY, M.D., F.R.A.C.P., F.R.C.P.A., is on associate professor of medicine and director of the department of Immunology at the University of New South Wales at St. Vincent's Hospital in Sydney, Australia. Doctor Penny initiated his research in immunology and immunopathology at the Institute of Cancer Research at New York's Columbia University.

**Abbreviations**

| | |
|---|---|
| Ab | Antibody |
| Ag | Antigen |
| C | Complement |
| IC (s) | Immune Complex (es) |
| Ig | Immunoglobulin |
| GN | Glomerulonephritis |
| MPS | Mononuclear phagocytic system |
| PEG | Polyethylene glycol |
| PMN | Polymorphonuclear leukocyte |
| RA | Rheumatoid arthritis |
| RF | Rheumatoid factor |
| RIA | Radioimmune assay |
| SLE | Systemic lupus erythematosus |

This was characterized by a proliferative glomerulonephritis (GN) and generalized necrotizing vasculitis, associated with circulating and tissue ICs and reduction in total hemolytic C. The components of the circulating IC, namely bovine serum albumin, rabbit Ab and C were identified within the glomerulus and vessel walls. While the polymorphonuclear leukocyte (PMN) comprised the predominant inflammatory cell in the vasculitic lesions, marked endothelial proliferation without a cellular infiltrate characterized the glomerular lesion. As this model was not representative of the typical acute GN in humans, an attempt was then made to produce a more representative model in rabbits using daily injections of bovine serum albumin. The aim was to maintain a continuous level of circulating antigen-antibody complexes.[4] Chronic serum sickness developed when circulating complexes persisted for more than two weeks. In contrast to the acute serum sickness model, the glomerular lesion was associated with a marked cellular infiltrate and electron dense basement membrane deposits which persisted for six to twelve months following cessation of the antigenic challenge.

Thus, an IC disease was produced in experimental animals by the introduction of an exogenous Ag. Circulating IC's were formed which were able to activate serum C and result in a tissue inflammatory reaction. The latter, however, was influenced by the nature and the quantity of circulating IC's.[4]

## Immune Complex Disease in Animals

Chronic viral infection in genetically susceptible animals may result in IC disease, usually manifested as GN and vasculitis. Commonly recognized viral agents in the mouse include lymphocytic choriomeningitis, lactic dehydrogenase and a variety of oncornaviruses. In the horse, "equine anemia" virus has been identified and in the mink, "Aleutian disease" virus.[5]

The New Zealand Black/White Fl hybrid female mouse chronically harbors oncornaviruses and develops a disease similar to human SLE associated with severe proliferative GN. Impaired T-cell function in these mice may be related to either reduced suppressor T-cell or increased helper T-cell activity leading to B-cell over-activity and excessive Ab production. Antibodies are directed against exogenous [viral] and endogenous [nuclear, T cell, erythrocyte] antigens and may result in the formation of circulating ICs.[6] In two further murine models, the BXSB and the MRL/l, circulating ICs have been identified by the Raji cell radioimmunoassay (RIA), mixed cryoglobulins and C activation.[7] Immune complex GN and vasculitis result in death by four to five months. In the BXSB, there is a clear male predilection whereas a slight female predilection exists in the MRL/1.

Viruses may persist in the circulation as ICs, maintain their infectivity and ability to replicate, and act as a continual source of Ag in the production of circulating viral Ag-Ab complexes.[8] Oncornaviral Ag's incorporated into the host genome in man and mouse may result in formation of antigenic nuclear material. This material, composed of host and viral nucleic acids, may be able to elicit an Ab response in the host.

Conversely, genetic factors may predispose to chronicity of viremia and expression of an IC disease. Predominance of male disease in the BXSB, early onset of IC disease in New Zealand Black/White Fl males following castration and delayed disease onset in castrated females together with the female predominance in human SLE, all suggest a hormonal influence in the modulation of disease expression.[9]

## (A) Clearance of Circulating Immune Complexes

*(1) The nature of the immune complex:* Most circulating ICs appear to be cleared from serum by fixed and circulating mononuclear phagocytic cells which possess C and Fc surface receptors. Pathogenetic ICs sometimes deposit on vascular basement membranes, activate serum C and initiate an inflammatory cellular infiltrate. Pathogenic complexes (19S, MW $10^6$ daltons) usually are soluble,[10] not readily phagocytosed and circulate in slight to moderate Ag excess.[11] Larger complexes are quickly cleared by the mononuclear phagocytic system (MPS), while smaller non-C fixing complexes (7S) are cleared by spleen although they may also be fixed in glomeruli, blood vessels and choroid plexus.[12] Low affinity Ab containing complexes appear to be less efficiently cleared by the MPS.[12]

With respect to the antigenic moiety, large Ag's (e.g. viral particles, circulating DNA) may be rapidly eliminated without Ab while a small single dose of Ag (*e.g.,* bovine serum albumin) may not persist in sufficient quantities to form pathogenic complexes when Ab is produced.[13] Potent Ag's evoke a high titer antibody response where IC disease is unlikely to develop, usually with rapid Ag elimination. In addition, weak Ag's may result in formation of pathogenic complexes via production of reduced amounts of Ab and/or low affinity Ab.[14] A low affinity Ab response may be genetically determined via linkage to the immune response (Ir) gene, and in this respect, IC disease may have a genetic basis. Although it is tempting to speculate on the quantity and function of the Ab produced, in particular the relationship to the gene, there is only sparse data linking the HLA system in man with the development of IC disease.[15]

*(2) Mononuclear phagocytic system (MPS):* This name replaces the older term, reticuloendothelial system, and refers collectively to circulating monocytes and fixed tissue macrophages. Clearance of ICs by the MPS appears to be a function of the degree of lattice formation and the presence of specific Ig subclasses $IgG_1$ and $IgG_3$ within the complex.[11] In experimental serum sickness, 99% of ICs are eliminated by the MPS, predominantly by hepatic Kupffer cells, leaving less than 1% to produce any tissue damage.[4] In man, unlike the experimental animal, it cannot be assumed that the MPS is fully functional at the onset of clinical IC disease. Clearance of ICs appears to be independent of C receptor binding and requires an intact Fc region on the IgG within the complex for recognition by the MPS surface Fc receptors.[16] At the onset of acute serum sickness, hepatic Kupffer cells are saturated by ICs and are unable to clear further circulating ICs, allowing complexes to remain for longer periods in serum.[4] Corticosteroids prolong the circulation time of injected performed ICs.[17] In chronic serum sickness GN, steroids increase the uptake of ICs by the glomerular mesangium possibly by decreasing basement membrane permeability to the ICs.[18] It is possible that the most philogistic IC's may never enter the circulation or if so are rapidly removed such that the ICs detected in serum may only reflect the presence of injurious complexes in other tissue sites.

## (B) Mechanisms of Immune Complex Localization in Tissues

Immune complex deposition on vascular basement membranes appears to coincide with a local increase in capillary permeability. This may result from (a) vasoactive amines released locally from basophils and platelets producing endothelial retraction[19] or (b) endothelial damage related to ischemia or ongoing inflammation.[20] Once the vascular integrity is breached by an inflammatory process, circulating complexes are probably readily deposited. Immune complexes do not appear to adhere to nor do they appear to be phagocystosed by vascular endothelium although if endothelial C and Fc receptors existed, these could help to localize complexes. Demonstration of glomerular C3b receptors,[21] although localized to the epithelial side of the basement membrane,[22] may still contribute to IC localization.

Various non-immunologic factors are involved in IC deposition. These can be readily appreciated in human leukocytoclastic vasculitis, where IC deposition is most prominent in the lower limb and over areas of pressure.[23] Prolonged contact time between endothelium, circulating cells, especially platelets, and ICs appears to influence IC deposition. A reduced dermal capil-

lary blood flow rate may follow (a) an increase in intravenular and intracapillary pressure (gravity, venous obstruction), (b) reduced body surface temperature, (c) a local increase in blood viscosity and (d) vasodilation. A propensity to intravascular coagulation with fibrin deposition and platelet aggregation is associated with decreased flow rate.[23] Endothelial damage *de novo* may result in decreasing plasminogen activator synthesis leading to impaired local fibrinolysis and decreased clearance of fibrin deposits.[24]

The anatomy of the local circulation influences IC deposition. Glomerulus, choroid plexus, synovium, and uveal tract share a high blood flow/unit tissue mass and all produce an ultrafiltrate of plasma. These sites can potentially trap large quantities of circulating ICs and are high risk sites in man. A charge similarity between Clq and exposed collagen in vascular basement membranes based on similar amino acid sequences may allow circulating Clq reactive complexes to bind to exposed collagen, secreted in part by endothelial cells.[25]

### (C) Mediators of Immune Complex Induced Inflammation

*(1) Platelets:* Human platelets possess receptors for the Fc portion of IgG but not for C3.[26] Complexes appear to bind to circulating platelets, resulting in aggregation and release of nucleotides, vasoactive amines and the pro-coagulant platelet factor three.[27] In addition, thrombin, ADP, exposed collagen, prostaglandins, and platelet-activating factor (PAF), which is released from basophils and mast cells, can all cause platelet aggregation.[28] Basic proteins released from platelets and PMNs are capable of increasing vascular permeability. While the role of platelets in human IC deposition is unclear, they are involved in IC deposition in experimental acute serum sickness.[27] Pretreatment of experimental animals with antihistamines reduces IC deposition.[20] Cyproheptadine or hydroxyzine choloride, used in a diphtheria epidemic in conjunction with diphtheria anti-toxin, reduced the incidence of serum sickness reactions by seven fold over that which developed in controls.[29] This observation suggested that the vasoactive amines, histamine and serotonin, did play a role in IC deposition in man.

*(2) Polymorphonuclear Leukocytes:* PMNs comprise the dominant primary cellular response to tissue ICs. Their entry is mediated via components of the C system.[30] In the Arthus reaction, PMNs predominate in the four hour lesion and are progressively replaced by mononuclear cells, comprising 50% of the cellular infiltrate by 24 hours. However, cutaneous allergic vasculitis in man is associated with a prolonged PMN tissue response which persists together with tissue ICs for up to four days.[31] This difference may be related to continual IC deposition or to local IC formation or possibly a superimposed Schwartzmann-type reaction. Experimentally induced neutropenia or thrombocytopenia abolishes the generalized vasculitis in the acute serum sickness model, but does not influence the GN. This would indicate that PMNs or platelets are not a prerequisite for the renal lesion.[32]

PMNs undergo chemotaxis to the site of IC deposition under the influence of C567,* C5a and to a lesser extent C3a.[33] In addition, other less potent chemotactic agents are liberated during the inflammatory process (basic lysosomal proteins, kallikrein, plasminogen activator, fibrin degradation products).[33] Complexes bind to Fc and C3b receptors on the neutrophil. They undergo phagocytosis which results in a release of lysosomal enzymes.[34] Extracellular release of lysosomal contents (collagenase, elastase, cationic proteins, hydrogen ions, etc.) and possibly superoxides, singlet oxygen and peroxide cause further tissue damage and exacerbate the inflammatory response. These increase vascular permeability, degranulate mast cells and initiate *in vivo* coagulation via thromboplastin generation.[35,36]

*(3) Complement System:* Immune complexes activate the classical and alternative C pathway, with the former generally predominating. Complexes containing IgM and IgG (especially $IgG_1$ and $IgG_3$) activate the classical C pathway while IgA complexes, like zymosan, endotoxin and initiating factor (factor I) the alternative C pathway.[37] The presence of the early sequence components Clq, C4 and C2 at this tissue site indicate classical pathway activation. Properdin factors B and D indicate alternative pathway activation.[38] Large amounts of C3 are detected in tissues undoubtedly because C3 represents the

---

**The asterisk indicates the activated state of the molecule. (Standard World Health Organization Nomenclature is a bar over the molecular symbol as shown in the figures herein. Because reproduction of this nomenclature in the text was not feasible, the bar is herein represented by an asterisk.)*

amplification step in the C cascade with the highest level of any C component in serum.

Activation products of C are responsible for:

- C3b mediated immune adherence of ICs to PMNs, eosinophils, and mononuclear phagocytes.[37] C4b plays a lesser role in immune adhence. In addition, binding of ICs via a C receptor can result in exocytosis of lysosomal granules;
- Chemotaxis of leukocytes mediated via C567,* C5a, and C3a.[33,37] It has been implied that C fragments may also be associated with lymphocyte chemotaxis;[39]
- Formation of the anaphylatoxins C3a and C5a, which lead to release of granules from basophils and mast cells;[37]
- Cell lysis from surface binding of the terminal C components either following direct binding of Ab to an Ag on the cell surface or via a "bystander reaction" where preformed ICs passively bind to the cell membrane leading to C activation;
- Activation of B-lymphocytes by C3 breakdown products.[40]

*(4) Coagulation, fibrinolysis and the kinin system:* While earlier evidence suggested that ICs could activate Hageman factor (Factor XII) directly resulting in coagulation, this now appears not to be so.[41] However, the role of ICs with fixed C1q have not been fully studied with respect to their ability to bind factor XII.[42] Indirectly initiated coagulation resulting from thromboplastin generation, release of lysosomal contents or via exposure of basement membrane collagen appears to be the chief mechanism for *in vivo* coagulation.[36] The proteolytic enzyme plasmin in addition to degrading fibrinogin-fibrin complexes appears to generate kinins and activate the C system by proteolysis of C1 and C3.[42]

*(5) Lymphocytes:* Experimentally, ICs may suppress and enhance lymphocyte activation.[35,43,44] At the B-cell level, IC's can modulate B-cell function depending on the stage of differentiation and the nature of its surface receptors. In general, ICs result in B-cell inactivation[43] requiring for this action an intact Fc region on the Ab. This suggests that B-cell inactivation occurs by binding of the IC to the lymphocyte Fc receptor. In addition, excess quantities of Ag or ICs presumably related to the complexed Ag can inhibit specific Ab production by lymphocytes.

With respect to T-cell function, ICs similarly appear to inhibit overall T-cell function. They may do so by inhibiting helper T-cell activity or by activation of suppressor T-cells.[45] Recent T-cell subsets have been found to bind the Fc region of IgM ($T\mu$)[46] or the Fc region of IgG ($T\gamma$).[46] Binding of ICs containing IgM or IgG antibody may thus lead to the generation of helper or suppressor cell activity respectively. In addition, ICs may abrogate the proliferative response of mouse spleen cells to both B- and T-cell mitogens.[47] ICs immobilized on plastic surfaces inhibit blastogenesis, while suspensions of the same ICs are not inhibitory.[48]

With respect to the effect of ICs on lymphocyte function in human disease, most data relates to their role as "blocking factors" in malignancy.[47] Immune complexes may inhibit the T-cell cytotoxic response to tumor cells by specific activation of suppressor T-cells. They may inhibit T-cell function by binding the complexed tumor Ag to the T-cell surface antigen receptor. Third, they may inhibit B-cell function and Ab production by cross-linking B-cells via binding to their receptors.[35]

The role of the tissue lymphocyte in IC-mediated tissue injury is unclear. However, it has been demonstrated that B-type lymphoblastoid cells and activated T-lymphocytes undergo chemotaxis to C components and specific Ag respectively.[47] In cutaneous lymphocytic vasculitis, a perivascular lymphocytic infiltrate is associated with IC deposition, but again lymphocyte function is unknown.[48,49]

Further, ICs may modulate the immune response via the formation of anti-idiotypic Ab.[50] These Ab's bind to the Ag combining sites on specific Ab and in addition react with the Ag receptor on the lymphocyte surface.[51] Thus, ICs can possess anti-receptor activity with their binding leading to impaired function of a specific receptor-bearing cell which may be either B- or T-cell.

---

*This concludes part one of our three part series on immune complexes and human disease. Part two is scheduled for the September issue. A complete list of references is available upon request to: Illinois Medical Journal, 55 E. Monroe, Suite 3510, Chicago 60603.*




Edited By JOHN M. BEAL, M.D.

*Surgical Grand Rounds are held weekly on Tuesday at 5:00 p.m. in the Offield Auditorium of the Passavant Pavilion of Northwestern Memorial Hospital. Patient presentations from Northwestern Memorial Hospital and the Veterans Administration Lakeside Hospital form the basis of the discussions. This case report was part of the Surgical Grand Rounds of June 7, 1977.*

# Computerized Whole Body Tomography

**Dr. Harvey L. Neiman:** In 1972, Godfrey Hounsfield and his co-workers at the EMI laboratories in London, England, announced the development of the first computerized tomographic unit for clinical use. This first generation machine was a dedicated brain scanner, and systems for scanning other parts of the body were developed shortly thereafter.

The clinical unit for brain scanning was actually quite crude in the sense that the scanning times were very long—on the order of five minutes. Time for reconstruction of the image was also very long, and therefore the clinical applications of this method were limited. The possibilities of whole-body scanning were theoretically so exciting, however, that numerous technical advances proceeded rapidly, such that scanning times are now in the 2 to 20 second range in clinically available units.

I would like to briefly review the concept of CT scanning, a little about the physics, and then primarily to discuss case material which is illustrative of the present clinical indications. CT scanners are conceptually similar and the major components of all manufacturers' products have much in common. This discussion applies to most of the currently available CT models.

In a CT system, the patient is placed in the center of an X-ray gantry. The gantry houses an X-ray tube and a series of detectors which are directly opposite the X-ray source and which have the ability to move synchronously with it. The detectors are of two varieties. Scintillation detectors consist of a luminescent crystal such as activated sodium iodide or bismuth germinate and an optically coupled photomultiplier tube. Gas detectors, usually xenon, can also be utilized.

Presently, the most commonly utilized instrument uses a fan shaped beam of X-rays which has an angle of 10°. To obtain a cross-sectional image, the X-ray source, as well as a group of 30 detectors, move synchronously in a linear fashion across the patient. The X-ray tube and detectors are then rotated 10° and the procedure repeated until the volume of tissue is viewed from 180°. This system allows the completion of a scan in under 20 seconds.

Head scanners can utilize longer scanning times, since motion can be prevented by stabilizing the head. In the abdomen and chest however, faster scans are needed to prevent motion unsharpness from peristaltic activity, respiratory motion, etc. A "third generation scanner" utilizes a fan shaped beam of approximately 30° and a large number of gas detectors (approximately 300). The X-ray tube and detectors rotate continuously about the patient without any linear motion. These systems scan one section in approximately 5 seconds. There are obvious clinical advantages to this scanning time. However, there are disadvantages in the potential for creating artifacts and the need for more carefully synchronizing the detector array. A further refinement consists of a stationary

ring of approximately 600 detectors with only the X-ray tube rotating about the patient.

The second major component, of course, is the computer. Assume that a very narrow X-ray beam traverses an individual at a specific point. A portion of that X-ray beam is attenuated and a portion of it passes through the individual and then impinges upon a detector which converts the energy ultimately to an electrical impulse. A known amount of X-ray energy is therefore sent out. A detectable amount is recorded and the difference between the two is an absorbed dose. The data obtained by this method for a specific core of tissue gives a "profile" of the attenuation of X-rays in the tissue traversed. Each point is ultimately "looked at" from 180 different angles. These profiles then provide the necessary information to reconstruct by an appropriate algorithm, *i.e.*, "filtered back projection," the attenuation coefficient for each point within an object studied. The electrical information is recorded in a digital format by a computer. A line printer can then produce a numerical printout of the absorption coefficient for each picture element that has been reconstructed. In a clinical setting, however, this information is converted into an analog optical image which is viewed on a television monitor and then photographed.

The third major component of a CT system is the console where the operator can communicate with the computers and X-ray units and where the reconstructed image appears on the television screen for viewing.

The X-ray attenuation characteristics of tissues have been set such that water is 0 Hounsfield units, dense bone is +1,000 Hounsfield units and air is −1,000 Hounsfield units. A shade of gray, or for that matter a color, can be assigned to a range of Hounsfield units such that the viewed image is a recognizable anatomic cross-section.

## Specific Utilizations

Obviously, in the central nervous system the use of computed tomography is well established. I think that most physicians would agree that few medical instruments have revolutionized the practice of a subspeciality of medicine, namely the neurologic sciences, as has the CT head unit. I would like to concentrate however, on the use of CT in the thorax, abdomen, and pelvis.

The first illustration is through the midthorax. (Fig. 1) I think that you can readily appreciate the heart and pulmonary vascularity. At the present time with 2 second to 18 second scanners, studies of the heart are not possible. Extremely fast scanners, however, gated to the ECG, are being developed.

There are several indications for computed tomography of the mediastinum. (1) Not infrequently, a lesion may be partially hidden by the mediastinum. This is particularly true in the left lower lobe. Computed tomography gives a clear demonstration of these lesions without superimposed normal structures. (2) Differentiation of a large pulmonary vascular structure from hilar lymphadenopathy particularly by using contrast enhancement. (3) Staging of mediastinal tumors. Subcarinal lymph nodes are particularly well visualized when they enlarge and encroach on the azygoesophageal recess. Pariesophageal and internal mammary lymph nodes are also well seen. (4) Characterization of mediastinal lesions (Fig. 2) by their attenuation coefficient. This is particularly helpful in diagnosing lesions containing fat such as a prominent pericardial fat pad. Thoracic aortic aneurysms and aortic disections also lend themselves to identification by computed tomography. (5) Computed tomography's cross-sectional approach allows for a different viewpoint of a questionably abnormal mediastinum. This is particularly helpful where a mediastinal contour is equivocal and standard radiography is unable to sort out tortous or dilated great vessels from normal mediastinal structures. (6) Evaluation of previously nonvisible structures. The diaphragmatic crura are well seen in computed tomography. Abnormalities such as hematomas and enlarged lymph nodes in this area can also be evaluated.

In the pulmonary parenchyma, the major contribution of computed tomography is in the detection of otherwise occult pulmonary nodules. CT has proven to be most useful in diagnosing nodules located just beneath the pleura, adjacent to the heart or mediastinum, and the costophrenic angles. Initial experience indicates that computed tomography detects more nodules than either chest radiography or conventional whole lung tomography. Computed body tomography should be utilized for complete evaluation in those patients whose specific therapeutic modality is to be chosen based on the presence or absence of pulmonary metastases. In addition, where a parenchymal resection is contemplated based on the presence of a single nodule, CT may detect further metastatic deposits.



Fig. 1
**Note the heart and pulmonary vascularity. At this window level and width mediastinal detail is not obtained.**




Fig. 2
**Normal upper abdomen—not the excellent visualization of the body and tail of the pancreas (arrowheads), the aorta (arrow), and adjacent inferior vena cava are well seen. The superior mesenteric artery is seen as a grey dot just ventral to the aorta.**

## Abdominal Examination

At this time, computed tomography appears to show some of the most exciting possibilities in the abdomen. It appears to nicely complement presently available imaging modalities. It has outstanding potential in staging of intra-abdominal masses as it exquisitely defines tissue planes. Obesity and intestinal gas are not a problem and therefore the technique is useful in those individuals where ultrasound fails. By convention, CT scans in the abdomen are displayed as though one is viewing the transected specimen from the feet towards the head. In a supine scan therefore, the patient's left is on the viewer's right (Fig. 2).

The pancreas lies in the upper abdomen with the head adjacent to the second portion of the duodenum. The duodenal sweep is displayed by having the patient ingest oral iodinated contrast material. The uncinate process is seen just posterior to the superior mesenteric vessels. The body of the pancreas is located ventral to the superior mesenteric artery. The splenic vein lies dorsal to the body and tail of the pancreas. The pancreatic tail may be variable in its location, but usually lies close to the hilum of the spleen. The peripancreatic fat, which is of a lower CT density than the pancreas, aids in visualization of this organ. The diagnosis of carcinoma of the pancreas is based on the presence of a localized mass, alteration in the uniform tapering of the pancreas, obliteration of the posterior peripancreatic fat plane, and an indistinct pancreatic margin. Obviously, the presence of secondary signs of a mass are also quite helpful; dilation of the biliary ducts or pancreatic duct, distension of the gallbladder, or presence of liver metastasis.

Acute pancreatitis tends to have diffuse involvement and slightly decreased density of the gland. If the disease process is focal, however, the appearance is similar to carcinoma. The clinical information should aid in differentiation. The minute calcifications of chronic pancreatitis are easily seen. Pancreatic pseudocysts are easily detected by CT with the pseudocyst having a decreased attenuation coefficient (Fig. 3). Early studies indicate that computed tomographic scanning of the pancreas has an accuracy in the range of 85%

## Liver Scans

The normal liver appears as a homogenous structure that has a higher density than that of the other intra-abdominal organs. Within the liver, linear branching structures are present which represent the intrahepatic vascularity, particularly the portal vein and its branches. Normal intrahepatic biliary radicals are not visible.

Solitary masses from hepatocellular carcinoma,

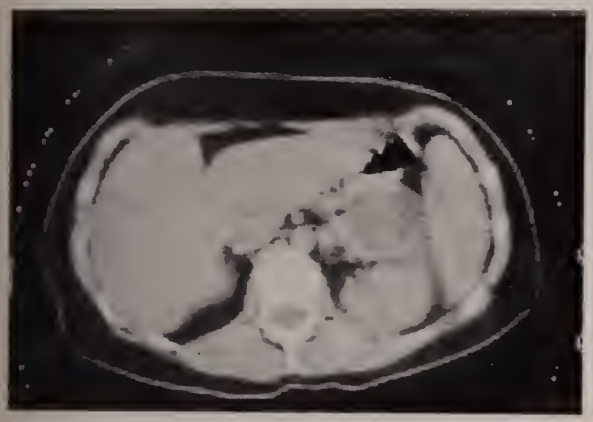


**Fig. 3**

**The low attenuation of the fluid within a pancreatic pseudocyst (arrow) allows for a high degree of sensitivity in detection of this entity.**

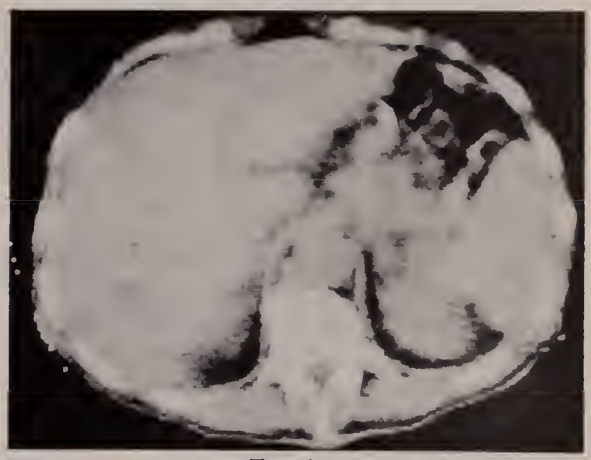


**Fig. 4**

**Marked inhomogeneity of the liver is indicative of diffuse metastatic involvement. Compare the appearance of the liver with that in Fig. 3.**

or metastasis are readily detected. Similarly, multiple defects within the liver from metastatic disease can be seen with a high degree of sensitivity. Primary and metastatic neoplasms within the liver appear as focal areas of slightly diminished density. (Fig. 4) Most are well marginated, although some have an indistinct margin with the remaining portion of the liver. Injection of iodinated contrast material frequently accentuates the liver-tumor interface and makes detection easier. Other space occupying lesions such as abscesses, cysts, and hematomas can also be detected by computed tomography and their attenuation coefficient suggests a specific diagnosis.

Computed tomography is able to detect variations in size or shape of the liver but otherwise cirrhosis cannot be diagnosed by this method. The exception is the fatty infiltration stage of cirrhosis when the liver has a diminished attenuation. Ascites is easily seen and CT serves therefore, as an adjunctive means of diagnosis in equivocal cases. Dilated intraphepatic biliary radicals, as well as a dilated common bile duct, can be detected by CT. The method is of obvious value in the differentiation of obstructive from nonobstructive jaundice. The accuracy of diagnosis in this setting is approximately 90%.

### Uses in Kidney Disease

The kidney is another area where CT scanning has proved to be very useful. CT compliments other imaging techniques in the workup of a renal mass. It is particularly useful in those cases where the diagnosis by ultrasound is equivocal or where the lesion cannot be seen because of technical factors. Solitary masses within the kidney can be easily detected by computed tomography and the nature of the mass lesion specified. Additionally, CT can aid in the pre-operative staging of renal cell carcinoma. The presence of periaortic adenopathy, liver metastasis, and renal vein involvement can all be suggested. Cystic lesions within the kidney present as a characteristic finding with an attenuation coefficient in the range of water. CT frequently demonstrates multiple cystic lesions when previous studies have demonstrated only a solitary cyst and similarly, the presence of an unsuspected renal mass is occasionally noted in a patient being scanned for a different clinical indication.

The presence of hydronephrosis can also be detected in the patient with nonfunctioning kidneys and nonvisualization on routine radiographic studies. Perinephric masses, such as hematoma and abscess can be diagnosed with a high degree of accuracy.

The adrenal gland can be visualized consistently and CT scanning is probably the noninvasive imaging technique for this organ. The technique should prove highly accurate for the diagnosis of pheochromocytoma and adrenal carcinoma. The accuracy in patients with adrenal adenoma and hyperplasia has not yet been determined.

Computed tomography has made a significant contribution in the detection of periaortic adenopathy, particularly in evaluating lymph node enlargement as seen with Hodgkin's disease and non-Hodgkin's lymphoma. It is less accurate in those neoplasms where the metastatic deposits do not enlarge lymph nodes; in these situations, lymphangiography better delineates nodal architecture. CT also provides a convenient and accurate means for follow up in patients with lymphoma following therapy.

The accuracy of CT in evaluating the presence of lymphoma in the spleen, liver, and mesenteric lymph nodes is unknown. Retroperitoneal hemorrhage, abscess and primary tumors can also be detected with a very high degree of accuracy. Intra-abdominal abscesses such as subphrenic and subhepatic lesions additionally, can be studied with computed tomography.

Although ultrasound is the primary imaging modality in the female pelvis, it does have certain limitations and therefore computed tomography is of value in the evaluation of both the female and male pelvis. Specifically, CT is able to define rather exactly, normal tissue planes and in particular, the pelvic side walls. CT aids in the staging of bladder tumors and that spread of neoplasm beyond the bladder wall is easily seen. Staging of the lesion with CT has abvious implications in the planning of a radiation therapy field. The position of the ureters with respect to a pelvic mass can also be determined following the administration of intravenous contrast material.

Although the uterus and ovaries can be visualized by CT, this procedure remains adjunctive to ultrasound with respect to imaging these structures. Similarly the prostate can be visualized by both modalities, but probably ultrasound remains the imaging technique of choice.

There are numerous other anatomic areas where CT has tremendous potential. For example, we are presently evaluating computed tomography in staging laryngeal neoplasms. Involvement of cartilagenous structures and subglottic extension should be detectable. Abnormalities of the spine, particularly spinal stenosis, can be diagnosed by CT and this cross-sectional approach gives a new dimension to imaging techniques. ◄

★

*Specialized Service*

IN

PROFESSIONAL LIABILITY INSURANCE

*is a high mark of distinction*

THE

MEDICAL PROTECTIVE COMPANY

FORT WAYNE, INDIANA

*Professional Protection Exclusively since 1899*

CHICAGO AREA OFFICE:

T. J. Pandak, J. C. Kunches, L. R. Gannon, and W. G. Prangle, Representatives

814 Commerce Drive, Suite 101B, Oak Brook, Illinois 60521 (312) 325-7314

SPRINGFIELD OFFICE: W. J. Nattermann, Representative

426½ South Fifth Street, Springfield 62701 (217) 544-2251




# Report on the 1978 AMA-RPS Annual Meeting

By Linda L. Hughey, M.D./Wilmette

*This is a monthly column which welcomes contributions, comments, and questions from interested readers. Address all correspondence to Dr. Linda Hughey, c/o the Illinois Medical Journal, 55 E. Monroe, Chicago, Ill. 60603.*

The AMA-RPS meeting in St. Louis was attended by 76 residents; 66 were official delegates. Illinois had six delegates of its allotted eleven. Any Illinois resident & member of the AMA in attendance would have been eligible for delegate status.

Twenty three states were represented as follows: Alabama (2), Arizona (4), California (5), Colorado (2), Connecticut (1), Florida (6), Illinois (6), Indiana (3), Iowa (1), Massachusetts (1), Michigan (3), Minnesota (4), Nebraska (2), New York (1), North Carolina (1), Pennsylvania (7), South Carolina (3), Tennessee (1), Texas (13), Virginia (1), Washington (2), Washington, D.C. (1), W. Virginia (1), Wisconsin (4), Canal Zone (1).

Residents hailed from a wide variety of specialty programs: Family Medicine (11), Internal Medicine (9), General Surgery, OB/GYN (5), Emergency Medicine, Psychiatry & Radiology (4), Anesthesia & Orthopedic Surgery (3), Neurologic Surgery, Neurology, Pathology (2), & one resident each from Allergy, Dematology, Otolaryngology, & Social Pediatrics. Obviously a wide range of specialties was represented, but an even wider geographic distribution is needed.

The convention included workshops on the impaired physician, cost containment, teaching skills, & organizational skills. After evening receptions & visits with state delegations, the residents scattered all over the city of St. Louis to sample night life under the Silver Arch.

The following Illinois residents attended as delegates:

James DeBord, University of Illinois;
Linda Hughey, University of Chicago;
Ira Isaacson, Northwestern University;
Benjamin LeCompte III, Rush-Pres. St. Luke's;
James McCreary, University of Ilinois and
Alan M. Sadov, Rush-Pres St. Luke's

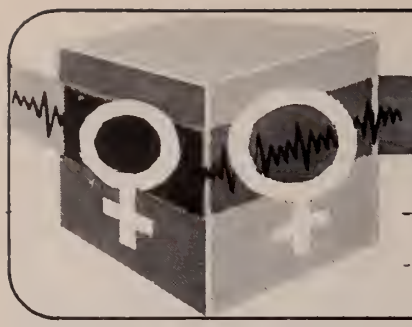
Illinois will be well represented on the Governing Council in the coming year. Dr. DeBord sits on the AMA Council on Scientific Affairs. Dr. Hughey was elected Secretary-Editor of the national AMA/RPS.

The majority of the RPS delegates had *never* attended an AMA convention before. That is the nature of the RPS—a young, rapidly changing group with a lot of room for new ideas and new faces. The Illinois RPS is seeking people interested in involvement at both state & national levels. If interested, you may contact Ira Isaacson, who is chairman of the Illinois RPS, at the ISMS office.

Attending a convention guarantees that you will at least meet interesting people, learn a bit about the politics of health care delivery, and find that residents share many common concerns. At most you may even walk away with a national office or some solutions to those shared problems. We shall look forward to hearing from you.

### A Call for Newsbits

Does your housestaff have any projects, problems, or headaches that might be of general interest? Please drop a note to Dr. Linda Hughey via the ISMS at 55 E. Monroe, Chicago, IL 60603. Resident activities may be publicized in this colunm. Furthermore, we may be able to help with problems either through the ISMS or AMA services to members. Please keep us posted, and we shall try in turn to keep you posted on useful events & services.



# pulse... of the ISMS auxiliary

Mrs. Eugene Vickery, Editor

## Growth Patterns



Mrs. Earl V. Klaren, President, ISMSA

These photos tell the story of a productive national convention in St. Louis in June. I hope they'll also bring a reminder to attend our own Fall Conference, September 19, 1978, at the Sheraton Northbrook Hotel. Fall Conference for the northern counties will center on "The Family in Question: Can It Survive?" An excellent roster of speakers will provoke your interest—and perhaps some solutions.

## National Convention Scenes



**Illinois Tops in Nation in AMA-ERF Contributions**

Mrs. Selig Hodes, (L) AMA-ERF State Chairman, and Mrs. Karl Reddies, Co-chairman, proudly display the achievement award they received during the National Convention in St. Louis. Illinois topped all other states in total contribution to American Medical Association Education and Research Foundation.

This is the fourth year that Illinois has won top honors. The Auxiliary appreciates the terrific cooperation and contributions of the Illinois State Medical Society in this project.



**Presidents Past—Present—and Future**

(L-R) Mrs. Edward Szewczyk, immediate past president of ISMSA; Mrs. Earl Klaren, 1978-79 president; and Mrs. R. S. Hoover, president-elect, paused for this picture during the Illinois State Breakfast in St. Louis during the AMA Convention.



Several of the delegates, alternates and members attending the AMA Auxiliary Convention in St. Louis June 18-21 were (left to right). Front row: Mrs. William Hodges, Mrs. Edward Szewczyk, past president; Mrs. Earl Klaren, ISMSA president, Mrs. Selig Hodes, Mrs. Karl Reddies. Second row: Mrs. Eugene Leonard, Mrs. Willard Scrivner, Mrs. Harlan English, Mrs. Wendell Roller, Mrs. Eugene Vickery. Standing (3rd row): Mrs. Henry Schorr, Mrs. August Martinucci, Mrs. Frank Holman, and Mrs. Norman Taylor.



**Ogle County Auxiliary Wins Regional Award At National Convention**

Mrs. Don Hinderliter, president of Ogle County Medical Auxiliary and newly elected 2nd Vice President of ISMS Auxiliary, was in St. Louis to receive her county's AMA-ERF award. Ogle County has nine members and they worked very hard to raise $212.00 per member for AMA-ERF. They were North Central's highest contributor and ranked second in the whole United States. Ogle is one of our newest counties, organized in 1975, and we're all very proud of them!


# MICHAEL REESE HEALTH PLAN

**has an immediate opening for a full-time Obstetrician-Gynecologist**

One who is board eligible or board certified and interested in practicing on the staff of a prestigious teaching medical center. Our health plan (HMO) provides pre-paid comprehensive inpatient and outpatient care to 12,500 patients at the Michael Reese Medical Center.

Salary and benefits are generous. For further details, please contact Dr. Joseph Shulruff, Medical Director.

**MICHAEL REESE HEALTH PLAN**

3055 COTTAGE GROVE
CHICAGO, IL 60616
Phone (312) 791-2852

*Equal opportunity employer m/f*

# How to Swim With Sharks: A Primer

Actually, nobody wants to swim with sharks. It is not an acknowledged sport, and it is neither enjoyable nor exhilarating. These instructions are written primarily for the benefit of those who, by virtue of their occupation, find they must swim and find that the water is infested with sharks.

It is of obvious importance to learn that the waters are shark infested before commencing to swim. It is safe to assume that this initial determination has already been made. If the waters were clearly not shark infested, this would be of little interest or value. If the waters were shark infested, the naive swimmer is by now probably beyond help; at the very least he has doubtless lost any interest in learning how to swim with sharks.

Finally, swimming with sharks is like any other skill: it cannot be learned from books alone; the novice must practice in order to develop the skill. The following rules simply set forth the fundamental principles which, if followed, will make it possible to survive while becoming expert through practice.

**Rules**

*1. Assume unidentified fish are sharks.*—Not all sharks look like sharks, and some fish which are not sharks sometimes act like sharks. Unless you have witnessed docile behavior in their presence or shed blood on more than one occasion, it is best to assume an unknown species is a shark. Inexperienced swimmers have been badly mangled by assuming that docile behavior in the absence of blood indicates that the fish is not a shark.

*2. Do not bleed.*—It is a cardinal principle that if you are injured either by accident or by intent you must not bleed. Experience shows that bleeding prompts an even more aggressive attack and will often provoke the participation of sharks which are uninvolved or, as noted above, are usually docile.

Admittedly, it is difficult not to bleed when injured. Indeed, at first this may seem impossible. Diligent practice, however, will permit the experienced swimmer to sustain a serious laceration without bleeding and without even exhibiting any loss of composure. This hemostatic reflex can in part be conditioned, but there may be constitutional aspects as well. Those who cannot learn to control their bleeding should not attempt to swim with sharks, for the peril is too great.

The control of bleeding has a positive protective element for the swimmer. The shark will be confused as to whether or not his attack has injured you, and confusion is to the swimmer's advantage. On the other hand, the shark may know he has injured you and be puzzled as to why you do not bleed or show distress. This also has a profound effect on sharks. They begin questioning their own potency or, alternatively, believe the swimmer to have supernatural powers.

*3. Counter any aggression promptly.*—Sharks rarely attack a swimmer without warning. Usually there is some tenative, exploratory aggressive action. It is important that the swimmer recognizes that this behavior is a prelude to an attack and takes prompt and vigorous remedial action. The appropriate countermove is a sharp blow to the nose. Almost invariably this will prevent a full-scale attack, for it makes it clear that you understand the shark's intentions and are prepared to use whatever force is necessary to repel his aggressive actions.

Some swimmers mistakenly believe that an ingratiating attitude will dispell an attack under these circumstances. This is not correct: such a response provokes a shark attack. Those who hold this erroneous view can usually be identified by their missing limb.

*4. Get out if someone is bleeding.*—If a swimmer (or shark) has been injured and is bleeding, get out of the water promptly. The presence of blood and the thrashing of water will elicit aggressive behavior even in the most docile of sharks. This latter group, poorly skilled in at-

tacking, often behaves irrationally and may attack uninvolved swimmers or sharks. Some are so inept that in the confusion they injure themselves.

No useful purpose is served in attempting to rescue the injured swimmer. He either will or will not survive the attack, and your intervention cannot protect him once blood has been shed. Those who survive such an attack rarely venture to swim with sharks again, an attitude which is readily understandable.

The lack of effective countermeasures to a fully developed shark attack emphasizes the importance of the earlier rules.

*5. Use anticipatory retaliation.*—A constant danger to the skilled swimmer is that the sharks will forget that he is skilled and may attack in error. Some sharks have notoriously poor memories in this regard. This memory loss can be prevented by a program of anticipatory retaliation. The skilled swimmer should engage in these activities periodically, and the periods should be less than the memory span of the shark. Thus, it is not possible to state fixed intervals. The procedure may need to be repeated frequently with forgetful sharks and need be done only once for sharks with total recall.

The procedure is essential the same as described under under rule three—a sharp blow to the nose. Here, however, the blow is unexpected and serves to remind the shark that you are both alert and unafraid. Swimmers should take care not to injure the shark and draw blood during this exercise for two reasons: First, sharks often bleed profusely, and this leads to the chaotic situation described under rule four. Second, if swimmers act in this fashion it may not be possible to distinguish swimmers from sharks. Indeed, renegade swimmers are far worse than sharks, for none of the rules or measures described here is effective in controlling their aggressive behavior.

*6. Disorganize an organized attack.*—Usually sharks are sufficiently self-centered that they do not act in concert against a swimmer. This lack of organization greatly reduces the risk of swimming among sharks. However, upon occasion the sharks may launch a coordinated attack upon a swimmer or even upon one of their number. While the latter event is of no particular concern to a swimmer, it is essential that one know how to handle an organized shark attack directed against a swimmer.

The proper strategy is diversion. Sharks can be diverted from their organized attack in one of two ways. First, sharks as a group are especially prone to internal discussion. An experienced swimmer can divert an organized attack by introducing something, often something minor or trivial, which sets the sharks to fighting among themselves. Usually by the time the internal conflict is settled the sharks cannot even recall what they were setting about to do, much less get organized to do it.

A second mechanism of diversion is to introduce something which so enrages the members of the group that they begin to lash out in all directions, even attacking inanimate objects in their fury.

What should be introduced? Unfortunately, different things prompt internal dissension or blind fury in different groups of sharks. Here one must be experienced in dealing with a given group of sharks, for what enrages one group will pass unnoted by another.

It is scarcely necessary to state that it is unethical for a swimmer under attack by a group of sharks to counter the attack by diverting them to another swimmer. It is, however, common to see this done by novice swimmers and by sharks when they fall under a concerted attack.

X

"How to Swim with Sharks," came into the *Journal* offices anonymously, with a single note reading "Perspectives in Biology and Medcine, Summer, 1973." If our readers have knowledge of authorship, the information will be gladly acknowledged, and credit given in a forthcoming issue.

# CHAIRMAN
## department of internal medicine

Fully accredited 1400 bed County chronic disease and rehabilitation facility affiliated with two medical schools is seeking a full time chairman, Department of Internal Medicine.

Prospective candidate requires: A minimum of five (5) years post graduate clinical experience, administrative experience and familiarity with medical school affiliation programs desirable; must be licensed to practice medicine or eligibility for same in the state of Illinois and must be certified by the American Board of Internal Medicine and a subspecialty or an interest in the latter. Will report to the medical director and responsible for attending staff, residency and specialty programs in a 108 bed acute care and 4 bed critical care unit.

Minimum salary $45,000 per annum plus a liberal fringe benefit package.

*All replies with C.V. to:*

JACK SOBEL, M.D., F.A.C.P.
MEDICAL DIRECTOR and CHIEF OF STAFF

**OAK FOREST HOSPITAL**
15900 SOUTH CICERO AVENUE
OAK FOREST, ILLINOIS 60452
An Equal Opportunity Employer M/F

---

**LOW-COST GROUP INSURANCE ANOTHER ISMS MEMBERSHIP PRIVILEGE**

**THE GROUP DISABILITY PLAN** ● Provides up to $1,732.00 monthly in the event of disability caused by Accident or Sickness. ● Special Guaranteed renewal feature. ● Protect your income and security.

**BUSINESS OVERHEAD EXPENSE PLAN** ● Pays your office overhead expense when disability strikes. ● Premiums are Tax Deductible. ● Pays in Addition to the Disability Plan Benefits.

**THE BASIC MAJOR MEDICAL EXPENSE PLAN** ● In or out of Hospital Benefits up to $25,000.00 per Disability. ● Up to $100.00 Daily Hospital Room and Board maximum. ● Subject to choice of deductible and 80% coinsurance.

**EXCESS MAJOR MEDICAL PLAN** ● Provides up to $500,000 for Medical Expenses. ● Supplements any Basic Major Medical Plan and is available with a $15,000, $20,000 and $25,000 deductible. Low group rates. ● Truly catastrophic coverage.

FOR INFORMATION, ASSISTANCE & DETAILS CONTACT:

Administrators:
PARKER, ALLESHIRE & COMPANY
ESTABLISHED 1901
Insurance

9933 N. Lawler Avenue
Skokie, Illinois 60077
Phone: 312-679-1000

# *Viewbox*

*(Continued from page 67)*

**Diagnosis: Bronchogenic carcinoma of left upper lung.**

Figures 1 and 2 were read in the emergency room as normal. Indeed, there is no fracture or dislocation present. There is, however, a large radiodensity occupying most of the visible lung field. This mass is present on both internal and external rotation films. The patient was called back to the hospital on the following day and chest film (Figure 3) showed a huge left lung mass. This proved to be a bronchogenic carcinoma and was responsible for the patient's symptoms.

The moral to this story is to avoid focusing (either mentally or visually) solely on your original suspicions. Because shoulder films were ordered, the orginal film reader looked only at the bones. She saw no fracture or dislocation and so interpreted the films as normal. The large mass was missed not because it is a subtle or difficult finding, but because no one directed attention away from their primary consideration. Examine *ALL* of the film. It just takes an extra few seconds.



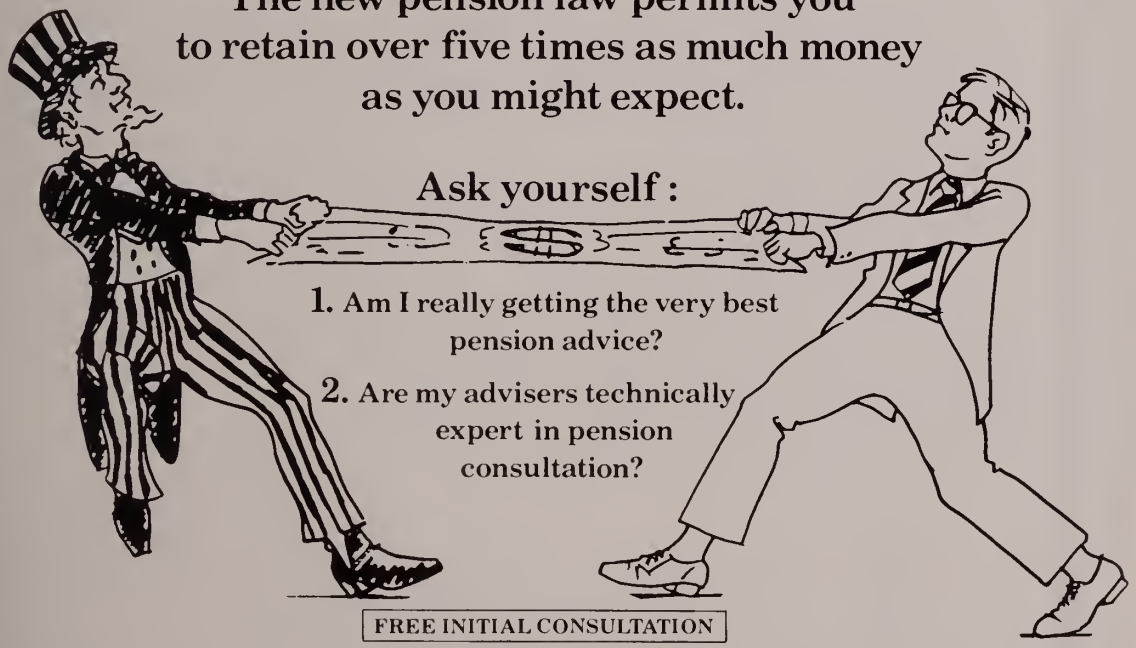
**Figure 3**
**Bronchogenic carcinoma occupying left upper lung.**


The new pension law permits you to retain over five times as much money as you might expect.

Ask yourself:

1. Am I really getting the very best pension advice?

2. Are my advisers technically expert in pension consultation?



FREE INITIAL CONSULTATION

American Society Pension Actuaries

Consultants to the Chicago Medical Society Employees Pension Plan

National Association Pension Consultants

Mann, Levine & Weiss, Ltd. 3525 W. Peterson, Chicago, IL 60659

(312) 539-7820 Pension Consultants and Plan Designers (312) 539-7820

# IMPAC

**ILLINOIS MEDICAL POLITICAL ACTION COMMITTEE**
55 East Monroe Street
Chicago, Illinois 60603
312/782-1963

NONPARTISAN

Dear Doctor:

A recently released Washington survey indicated that in the next four years, physicians will become the most politically powerful group in the county. This was attributed to three factors:

1) *physicians are thought to be creditable;*

2) *physicians are united in their efforts; and*

3) *physicians are willing to use their time and money to support causes they are interested in.*

As Chairman of the Illinois Medical Political Action Committee, I find this survey particularly interesting since half of the physicians in Illinois have not taken the easiest step in achieving a goal to which we, as citizens and physicians, must be committed -- good government. Fifty percent of my fellow physicians have not yet joined IMPAC.

In these days of double-digit inflation and ever-increasing government regulation of our lives, no single item can be higher on our priority list than electing top quality people to government service. IMPAC is committed to this goal and you can help by joining. Mail your check to: IMPAC, 55 East Monroe Street, Suite 3510, Chicago, Illinois 60603.

Remember, IMPAC is scrupulously non-partisan. We contribute to good candidates without regard for political party affiliation.

Won't you join us in this important activity?

Herbert Sohn, M.D.

Herbert Sohn, M.D.
Chairman

Contributions are not limited to the suggested amount. Neither the Illinois State Medical Society nor the AMA will favor or disadvantage anyone based upon the amounts of or failure to make pac contributions. Copies of IMPAC & AMPAC reports are filed with and are available for purchase from the Federal Election Commission, Washington, D.C. Contributions are subject to the limitations of FEC regulations, Sections 110.1, 110.2 & 110.5. (Federal regulations require this notice.) IMPAC reports are also filed with the State Board of Elections, and are or will be available for purchase from the State Board of Elections, 1020 South Spring Street, Springfield, Illinois 62704.

# Doctor's News

**IPS TO HOLD FIFTH ANNUAL FALL WEEKEND MEETING**—The Illinois Psychiatric Society will hold its Fifth Annual Fall Weekend Meeting from October 6-8, at the Chicago Hyatt Regency O'Hare.

Jerome S. Beigler, M.D., president and Melvin Prosen, program chairman, have announced that the three-day session will feature symposia, workshops, lectures and film presentations on a variety of clinical and socio-economic issues. Those who participate in the entire program will be entitled to receive 14 hours of AMA Category 1 CME credit.

For further information, please contact Wendy J. Smith at the Society's offices, 55 East Monroe, Suite 3510, Chicago 60603 (312-782-1654).

**INTERSTATE SCIENTIFIC ASSEMBLY ANNOUNCED**—The 63rd Annual International Scientific Assembly of the Interstate Postgraduate Medical Association is scheduled for October 23-26 at the Washington Hilton Hotel in Washington, D.C. The program of clinical discussion and instruction is designed for primary care physicians practicing in the U.S. and Canada. For further information, please contact Alton Ochsner, M.D., program chairman, Interstate Postgraduate Medical Association, P.O. Box 1109, Madison, WI 53701.

**LAST INTRAV TRIP FOR 1978**—One of the ISMS travel programs for 1978 remains open for reservations. Persons interested in the West Indies Air/Sea Christmas Cruise scheduled for December 19-27, 1978, should contact the ISMS headquarters as soon as possible. Information on 1979 programs will be available in the near future.

**DEATH AWARENESS CONSORTIUM ANNOUNCED**—The Illinois Funeral Directors Association will sponsor a special program for health care professionals on September 20, from 9:30 a.m. to 4:30 p.m., in the Chicago Room at McCormick Place. The program, which is co-sponsored by ISMS, will feature speakers on coping with sudden death and mourning, a wholistic approach to grief and health care and several other topics. Interested persons should contact the Illinois Funeral Directors Association, 1045 Outer Park Drive, Suite 120, Springfield, 62704. A self-addressed, stamped envelope with prepayment is requested. The registration fee is $12.00, and $18.00 for both the seminar and luncheon.

**I QUIT SMOKING CLINICS**—The Illinois Interagency Council on Smoking and Disease and the American Cancer Society will sponsor a series of clinics in coming months. Clinics are also scheduled in cooperation with the Chicago Department of Health, and several will be held in Chicago suburbs and Rockford. For further information, contact the Illinois Interagency Council on Smoking and Disease, 20 N. Wacker Drive, Room 1240, Chicago 60606 (312-346-4675).

**SNAKE-BITE CENTER**—The Antivenin Committee of the American Association of Zoological Parks and Aquariums has announced that a 24-hour Antivenin Index Center is available to physicians seeking antidotes for snakebites. The center maintains a catalog of snake-bite antivenins stocked in North American zoos, laboratories and related institutions. They can inform treating physicians of the nearest sources and make arrangements for emergency delivery. Physicians who encounter this problem are asked to determine the scientific and vernacular name of the snake involved, and call 405-271-5454 to obtain the necessary information.

**CALL FOR ABSTRACTS**—The American College of Chest Physicians invites abstracts for the International Conference on Occupational Lung Disease, which will be held February 27-March 2, 1979, at the Hyatt Regency-Embarcadero in San Francisco. Papers on all aspects, including particle deposition, lung defenses, epidemiology and pathology are requested. They should not exceed 600 words in length and must be received by September 11, 1978. For further information, please write: Chairman, Scientific Program Committee, International Conference on Occupational Lung Disease, c/o ACCP, 911 Busse Highway, Park Ridge, IL 60068.

**PHYSICIANS IN THE NEWS**—**Clifton L. Reeder, M.D.**, Park Ridge, was installed as 1978-79 president of the Chicago Medical Society. Doctor Reeder is the chief executive officer and medical director of Bodimetric Profiles Division, American Service, Chicago, and also medical director and director of Bodimetric Profiles, Canada, Ltd.

The Chicago Medical Society also announced that **Lawrence L. Hirsch, M.D.**, Chicago, is their new president-elect. Doctor Hirsch, a member of the ISMS Board of Trustees and chairman of the Policy Committee, is the former chairman of the ISMS Publications Committee and current chairman of the department of family medicine at the Chicago Medical School. **Robert C. Hamilton, M.D.**, Chicago, was named chairman of the CMS Council, and **Finley W. Brown, Jr., M.D.**, was elected vice chairman. **Franklin Lounsbury, M.D.**, River Forest and **John P. Harrod, Jr., M.D.**, Chicago, were renamed to their respective posts as secretary and treasurer of the Society.

**Bertram B. Moss, M.D.**, Chicago, has been named co-director of the Illinois Masonic Medical Center Family Practice Center in Chicago. Doctor Moss, former director of the St. Joseph Hospital Family Health Center, was also appointed an adjunct associate professor of aging health care services for the UI School of Public Health. . . . The University of Illinois House Staff Association has elected new officers. **James McCreary, M.D.**, Cicero, was elected president, **Lawrence Pankau, M.D.**, Chicago, vice president and **Mary Louise Kaminski, M.D.**, Chicago, secretary-treasurer of the 460-member association.

The Chicago Laryngological and Otological Society has elected **George A. Sisson, M.D.**, Chicago to serve as their 1978-79 president. **William M. Gatti, M.D.**, Bannockburn and **Jack D. Clemis, M.D.**, Wilmette, were elected vice president and secretary-treasurer respectively.

The medical staff at Jackson Park Hospital has elected **Leonard I. Silverman, M.D.**, Chicago, to serve as their new president. . . . The citizens of Chicago's twelfth congressional district have chosen **Gilbert Bogen, M.D.**, a Chicago psychiatrist, to oppose republican incumbent U.S. Rep. Philip M. Crane in the November elections. . . . New officers of the Chicago Gynecological Society are: **Robert E. Lane, M.D.**, Northbrook, president, **Herman A. Strauss, M.D.**, Chicago vice president, **Michael P. MacLaverty, M.D.**, Chicago, president-elect, **Uwe W. Freese, M.D.**, Chicago, treasurer, **Antonio Scommegna, M.D.**, Chicago, secretary and **Holden K. Farrar, Jr., M.D.**, Winnetka, assistant secretary.

**RESOLUTIONS DEADLINE**—Proposed resolutions for the Interim Meeting of the ISMS House of Delegates must be postmarked no later than September 2, 1978, in order to be published in the *IMJ*. In accordance with a resolution passed at the 1978 Annual Meeting resolutions will be published in the Journal by author and subject *only*.

The final deadline for resolutions for the 1978 Interim meeting is October 7, 1978. Resolutions received after that date will be considered late resolutions and require special action for possible consideration.

# *President's Page*



## The Illinois Voluntary Effort

The Voluntary Effort (VE) to check the health cost spiral appears to be working.

Statistics released last month reveal that hospital costs rose at the equivalent of a 12.7% annual rate during the first four months of this year—down from a nearly 16% rate last year. In April, the 11.3% annualized rate of increase was the lowest of any month since 1974. While these figures are encouraging, they represent only a short-term decrease that will be increasingly difficult to hold and improve upon over the long run.

The goal of the VE—launched last November by AMA, AHA and Federation of American Hospitals—was to reduce hospital rate increases by 2% both this year and next. Its success thus far is largely attributable to the program's growing momentum at the state level.

Illinois is a good example. ISMS and the Illinois Hospital Association have united their cost containment programs and formed a steering committee to direct the VE in Illinois. In addition, the ISMS Task Force on Cost Effectiveness is continuing its activities and will serve as a valuable resource body for the steering committee. This type of cooperation within the health care "industry" serves to deflate the Carter Administration's charge that the VE is merely a charade to stall implementation of federal controls.

Obviously, the VE now must be viewed as a positive commitment. Nonetheless, the Administration's attempted power grab continues along with a move to undermine our initiatives. A classic example was the Justice Department's recent refusal—at the urging of HEW—to grant anti-trust exemptions to the VE.

If the Administration succeeds in ramming a mandatory hospital cost containment bill through Congress, it is reasonable to assume that physicians' fees will be the next target. Newly-installed AMA President Dr. Thomas Nesbitt acknowledged that possibility when he urged physicians to cut the rate of fee increases by one percent for each of the next two years. That formula—which parallels the VE goal—would bring the rate of fee escalation close to the "all items" rate of the Consumer Price Index.

The Administration has not yet convinced Congress that federal cost controls are needed. However, the Congressional viewpoint could radically change if year-end totals for the VE fall short of target.

The private sector of the health care system has made significant progress toward a solution to the cost problem. However, the ultimate success of this effort—and the future of our system—depends upon the combined efforts of each hospital and you, the practicing physicians. ◄

David S. Fox, M.D., President

**Travel Medical Seminar for all Members and Families of**

# ILLINOIS STATE MEDICAL SOCIETY

# WEST INDIES

## AIR/SEA CRUISE

A Sun-Swept Nine-Day Luxury Cruise Aboard the STELLA MARIS to beautiful, gem-like islands, seldom visited and still unspoiled.

**St. Croix, St. Thomas, Guadeloupe, St. Lucia, Grenada, St. Vincent, Bequia, Antigua, St. Barthelemy, and St. Maarten.**







Relax aboard a delightfully intimate crusie ship with the finest service and top international cuisine.

Come cruise with us under the summer sun of the Caribbean and leave the cold winds of winter behind.

Via chartered PAN AM® Jet Clipper

From $998

A Non-Regimented INTRAV® Deluxe Adventure

**DEPARTING CHICAGO —DECEMBER 19, RETURNING DECEMBER 27, 1978**

Send to: Illinois State Medical Society
55 East Monroe
Chicago, Illinois 60603

Enclosed is my check for $ _____ ($100 per person) as p

Names _____

Address _____

City _____ State _____ Zip _____

Area Code _____ Phone _____

Space Strictly Limited—Make Reservations Now

# EKG

*(Continued from page 63)*

**Answers:** **1. B & C** **2. E**

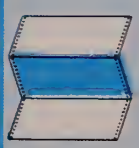
The electrocardiogram shows a tachycardia with a wide QRS complex. The QRS duration is approximately 0.14 seconds and the rate is 136 beats per minute. The black marks in lead II mark out P waves which indicate atrioventricular dissociation. This plus the wide based QRS complex suggests that this is a ventricular tachycardia. The RR cycles are not precisely regular but this is not unusual in ventricular tachycardia. The presence of sinus P waves at a rate of 86 beats per minute rules out atrial fibrillation as a consideration as well as atrial tachycardia. A fasicular ventricular tachycardia would have a normal QRS duration and a QRS contour suggesting incomplete right bundle branch block. This tachycardia is thought to arise in the posterior division of the left bundle branch. The QRS contour of the ventricular tachycardia in this patient resembles left bundle branch block. Therefore, the focus of the ventricular tachycardia is probably in the right ventricle. This patient subsequently underwent cardiac catheterization and coronary angiography to evaluate his cardiac anatomy. The coronary arteriogram showed a totally occluded right coronary artery and a discreet paradoxically contracting posterior left ventricular aneurysm. All of the intracardiac pressures were within normal limits. Surgery did not seem justified on the basis of his cardiac anatomy since the distal right coronary artery was not well visualized and the posterior left ventricular aneurysm was too small. A decision was made to treat the patient with medications utilizing drug levels to maximally tolerated doses. On a combination of Procainamide, 750 mg. Q 6 hours and Disopyramide, 200 mg. Q 6 hours with Lanoxin and Lasix, the tachycardias were controlled. The patient was gradually ambulated and subsequently was discharged from the hospital. He continues to do well without further tachycardias at eight months of follow-up. The prognosis in cases of ventricular tachycardia is related to the severity of the underlying heart disease, that is, congestive heart failure or Digitalis intoxication or the severity of coronary artery disease. In this patient's case, he only had single vessel coronary artery and his left ventricular function in sinus rhythm were normal.

Get PAID.

Time and time again, Medical Data Systems® users report: (1) substantial reductions in outstanding accounts receivable, (2) accelerated cash flow, (3) elimination of missing charges, and (4) faster turn around on third-party claims. Data processing services are more than fancy reports. MDS can be the difference between getting paid and not getting paid. And that's a good business basic.

S-Tek Computer Services — The Data Processing Tailors

MEDICAL DATA SYSTEMS®



Call or write our Sales Department for more information.

S-Tek
COMPUTER SERVICES, INC.
P.O. BOX 328 TERRE HAUTE, IN 47808 812-232-1385

Medical Data Systems® a registered trademark of S-Tek Computer Services Inc.



report

Illinois Society
American Association of Medical Assistants

# Along the Track of Education

By Magda Brown, Publicity Chairman

The American Association of Medical Assistants—Illinois Society, offers a well-rounded educational day for medical office staff on Sunday, October 1, 1978. The program is scheduled from 8:30 a.m. until 4:00 p.m. at the Ramada Inn, 500 W. River Road, Elgin, Ill. (312-695-3000)

Greetings by Mrs. Leslie Lee, President, AAMA Illinois Society and by Ms Mary Woolcott, President, Kane County Chapter, will open the days program. The meeting is coordinated by the Kane County Chapter under the direction of Mrs. Phyllis Harwood, CMA-AC.

Thomas R. Harwood, M.D., a pathologist and associate professor at Northwestern University medical and dental schools, will present a talk entitled "On The Track of Better Utilization of the Medical Laboratory." He will consider the purposes of lab. tests, interpretation of results, and utilizing tests in patient care.

Daniel Weiler, Assistant State's Attorney from Kane County and a member of the local, state, and national bar associations will discuss "Physician Liens, Estate Filings, and Closing a Medical Office Upon Death or Retirement of a Physician." He will stress the importance of estate filings, what the medical office assistant should know regarding them, the procedures to be followed and the rights of patients under these conditions.

"Current Bookkeeping Procedures" by Mr. David Hofer, a certified public accountant and field consultant for Medidentic, Inc., will focus in on bookkeeping methods utilized exclusively in medical offices. These include pegboard systems—both in check writing and daysheet journals, payroll procedures and requirements, quarterly payroll reports, balancing bank statements, and balancing and collection of accounts receivable.

Application has been filed with the American Association of Medical Assistants for consideration of awarding Continuing Education Units for the above listed subjects.

Registration fee includes luncheon. Before September 15th the cost for members is $10.00, students: $7.50, and non-members: $12.50. Late registration fee for members is $12.50, students: $10.00, and non-members: $15.00. Please make check payable to: AAMA, Illinois Society, Personal Development. Mail it with the form below to: Mrs. Phyllis Harwood, 1142 Florimond Dr., Elgin, 60120 (312-742-6804). The registration deadline is September 25, 1978.

---

please detach

Name _____ Address _____

AAMA Member _____ County Chapter _____

yes / no

# CLASSIFIED ADVERTISING

## POSITIONS & PRACTICE OPPORTUNITIES

**FULL TIME PHYSICIAN** for Industrial Clinic in Skokie. Surgical experience needed. Salary negotiable. Must have Illinois license. Call (312) 674-4800, Mrs. McCubbin.

**OPPORTUNITIES FOR PHYSICIANS IN INDIANA**—There are several excellent openings among the Indiana State Hospitals at various locations throughout the state for psychiatrists and physicians of other specialties, at most experience levels. A newly-revised salary schedule offers a very competitive income plus a generous package of fringe benefits. An adjunct practice is possible beyond the regular working hours and on-call responsibilities. Please reply with a copy of the c.v. to: Farabee & Associates, Inc., P.O. Box 472, Murray, KY 42071 or call (collect) (502) 753-9772. Farabee is retained by the Indiana Department of Mental Health.

**ACADEMIC DIRECTOR, INTERNAL MEDICINE:** University of Illinois affiliated community hospital seeks individual to be responsible for undergraduate, graduate and continuing medical education, and administration of residency and outpatient center. Physician we seek must be American Board of Internal Medicine certified. In return we offer a challenging and rewarding experience plus a competitive salary and benefit program. Send resume in complete confidence to: Box 917, c/o IMJ, 55 E. Monroe, Suite 3510, Chicago 60603.

**WANTED: INDUSTRIAL PHYSICIAN:** Unusual opportunity for Illinois licensed physician. Full time industrial work with minor traumatic surgery and physical examinations. Regular hours. Advancement for right person. Starting salary negotiable. Write to Box 920, c/o IMJ, 55 E. Monroe, Suite 3510, Chicago, 60603.

**ORTHOPEDIC SURGEON** who desires to locate in a rural area of southern Illinois needed to serve two community hospitals. One hour from St. Louis. Good educational system for children. Excellent recreation. Reply: T. K. Janssen, Administrator, Washington County Hospital, Nashville, Illinois 62263.

**WANTED—M.D.,** certified Family Practice, to direct and establish Family Practice Residency. Please reply to Box 927, c/o IMJ, 55 E. Monroe, Suite 3510, Chicago, 60603.

**ENT SPECIALIST** needed in a large, fast growing Chicago suburb. No other ENT specialist in town. Very favorable terms. Send resume to Box 926, c/o IMJ, 55 E. Monroe, Chicago, Illinois 60603.

**DERMATOLOGIST** needed for a large, fast growing Chicago suburb. Solo practice. Ideal for a second office. Office space available in a new medical complex. Very favorable terms. Send resume to Box 928, c/o IMJ, 55 E. Monroe, Chicago, Illinois 60603.

**OVERHEAD MOUNTING? WORKING LONG HOURS?** Consider working in a University Health Service. 40 hour week—positive fringe benefits including generous vacation times. Illinois license. Equal opportunity/affirmative action employer. Contact: M. M. Torray, M.D., Illinois State University, Normal, Illinois 61761. Tel.: 309-438-8655.

**MATTOON—CHARLESTON, ILLINOIS.** Sara Bush Lincoln Health Center Emergency Department has July opening for qualified physician. Guarantee $50,000-$55,000 with ideal working conditions and schedule. Send curriculum vitae to Stephen Allin, M.D., Emergency Department Director, P.O. Box 372, Mattoon, Illinois 61938 or call toll free 1-800-325-3982 for details.

**EMERGENCY DEPARTMENT PHYSICIAN:** Become part of an expanding, dynamic multispecialty clinic in midwest university community of 100,000. Excellent salary, benefits. Write or call Medical Director, Carle Clinic, Urbana, IL 61801, (217) 337-3239.

**FAMILY PRACTITIONER**—To associate with one senior general practitioner and one surgeon in rural southern Illinois. Excellent educational system and recreation. Financially sound community. One hour from St. Louis. JCAH 72-bed hospital in Nashville. Association available now. Contact: T. K. Janssen, Administrator, Washington County Hospital, Nashville, Illinois, (618) 327-8236.

**PHYSICIAN WITH EMPATHY TOWARD COLLEGE AGE** population to practice general medicine in 38 bed accredited hospital with large outpatient clinic. Salary negotiable. Excellent fringe benefits. Contact L. W. Combs, M.D., Director, Purdue University Student Hospital, West Lafayette, IN 47907, (317) 749-2441. Equal access/equal opportunity employer.

**PRIMARY CARE PHYSICIAN:** We seek a primary care physician, specialist or generalist, for JCAH-accredited hospital in central Illinois. Population: 4,500—service area 19,000. Hospital affilated with a major medical center and teaching hospital which provides opportunities for continuing medical education and support activities, ensuring against professional isolation. Hospital will furnish office in building on grounds and guaranteed base salary, plus other amenities. For further information write: Box 931, c/o IMJ, 55 E. Monroe, Suite 3510, Chicago, Ill. 60603.

**FAMILY PRACTICE PHYSICIAN** who is interested in obstetrics wanted to do primary care. $42,000 plus fringes (IRS-approved profit sharing plan) to start. Contact H. Osmus, Administrator, Hedges Clinic S.C., 222 Colorado, Frankfort, IL 60423; or (815) 469-2123.

**ILLINOIS—PEORIA**—Interviewing career Emergency Physicians for full-time openings starting immediately and Jan. 1. Opportunity to join young ACEP oriented physicians' group in 550-bed Medical-Surgical Hospital affiliated with Peoria School of Medicine. Good specialty backup. Flexible scheduling. Superior compensation with liberal fringe benefits including malpractice. Contact H. T. Stratton, M.D.; Methodist Medical Center, 221 NE Monroe, Peoria, IL 61636; (309) 672-4974 or (309) 672-5501.

**CHILD PSYCHIATRIST**—Full or part time. Modern residential treatment center for children & adolescents. Write or call Jose R. Sanchez, M.D., Medical Director, Chicago-Read Mental Health Center, 4200 N. Oak Park Ave., Chicago, Ill. 60634. (312) 794-4000.

**PEDIATRICIAN**—Full or part time. Modern residential treatment center for children & adolescents. Write or call Jose R. Sanchez, M.D., Medical Director, Chicago-Read Mental Health Center, 4200 N. Oak Park Ave., Chicago, Ill. 60634. (312) 794-4000.

**PSYCHIATRIST**—Adult Inpatient Services. Full or part time, for modern residential facility: Write or call Jose R. Sanchez, M.D., Medical Director, Chicago-Read Mental Health Center, 4200 N. Oak Park Ave., Chicago, Ill. 60634. (312) 794-4000.

**GENERAL PRACTITIONER, FAMILY PRACTITIONER,** needed for rural Illinois town near metropolitan area. Private office, full equipment and established practice available for sale or lease. Write: James R. Hastings, Executor, 301 NW 2nd St., Aledo, Illinois 61231, or telephone (309) 582-5388.

## FOR SALE, LEASE OR RENT

**MEDICAL OFFICE SUITE FOR RENT,** Lincoln-Belmont Bldg. 715-1200 square feet, available at once in full service, elevator, active professional building. Call Gary Solomon, (312) 334-5400.

**MEDICAL CENTER FOR RENT.** Complete and ready to open. 4300 sq. ft. at 2301 E. 95th Street, Chicago. Large waiting rm., 18 exam rms., x-ray rm., central a/c & heat. Call Gary Solomon, (312) 334-5400.

**SUITE TO LEASE** for Internist, Pediatrician, Psychologist, Psychiatrist or other medical practice. Suite is located in a high quality building with a growing medical community situated across from a major hospital. The complex already includes an outstanding lab, X-ray facility, pharmacy and 16 professionals. Arrangement provides flexibility for the new tenant to share a suite with an existing practice, to have office built in newly created bare space and to participate in the ownership and direction of the complex. STRONG Property Managers, Ltd. Agents, 201 W. Springfield, Champaign, IL 61820. (217) 356-2617.

**SPACIOUS** Northside Lakeview area medical office for rent. Newly remodeled. Five examining rooms, carpeted. Large furnished waiting room. Available now. Interested in Spanish speaking doctors only. Growing Spanish speaking area. Near Ashland-Lincoln and Belmont. Pharmacy space also availble, if desired. Please contact: Dr. Pedro O. Cabrera (Dentist) at 1442 W. Belmont or call (312) 528-0068.

**FOR SALE:** 31-year-old established general practice and clinic. Fully equipped and furnished. Clinic and practice can accommodate two doctors. Contact: Bob Billa, 2931 East Southcross Blvd., San Antonio, Texas 78212.

**LISLE-MEDICAL SUITE** available in prestigious modern building located on Rt. 53 in Lisle. X-ray facilities on premises. Zone controlled heating and air conditioning. Ample parking. Call 969-2850.

**FOR SALE:** Solo or Group Practice/south western Chicago suburb. Comprehensive Medical Center: Internal Medicine, OB-GYN, Pediatrics, Optometry, Dental, X-ray Equipment, Medical Lab and Pharmacy. 7000 sq ft., 15 fully equipped examining rooms plus business offices. Private parking. Estimated Annual Gross Income: middle six figures. Negotiable financing. Outstanding opportunity with excellent potential. Please direct inquires to: Box #933, c/o **ILLINOIS MEDICAL JOURNAL**, 55 E. Monroe, Chicago, IL 60603.

**RANCH-STYLE MODERN MEDICAL-DENTAL BUILDING FOR RENT:** Customized facilities to meet every medical and dental need. Ideal for family physician or group practice. 1500 to 2500 sq. ft. available. Armitage and Damen area, Chicago. Near St. Mary of Nazarene Hospital. Present physician re-locating leaving well established practice. (312) 472-5126 or 338-9347.

**GENERAL PRACTICE FOR SALE:** Excellent quality practice including industrial medicine. Northwest Suburban location with community hospital. Sale due to illness — Seller will assist in transition with hospital privileges, employees, etc. Contact Mark Gorman at 3916-67th Street, Kenosha, Wisconsin 53142. 414-654-9166.

## SITUATIONS WANTED

**DR. P. J. REDDY**—Male, 39 years—Psychiatry, M.D., D.P.M., F.R.C.P.(C), ABPN, with total ten years of wide experience in Psychiatry with Illinois license looking for place in private practice or a salaried job.

**DR. P. V. REDDY**—Female, 34 years—OB-GYN, M.D., M.R.C.O.G. (U.K.), American Board Certified with Illinois license. Total ten years in OB-GYN. Looking for place in private practice or a salaried job. Please contact Dr. P. J. Reddy, Union Hospital, Moose Jaw, Saskatchewan, Canada. Office—(306) 692-1841; Home—(306) 693-3288.

**BOARD CERTIFIED RADIOLOGIST,** 40, graduate of American medical school available for film reading in office, clinic or home. Daily pick-up service if desired. Excellent references. Please contact Illinois Medical Journal, Box No. 930, 55 East Monroe, Chicago, Illinois 60603.

**INTERNIST**—29, university trained seeks partnership or group practice opportunity in Chicago area. Available July 1979. Box 929 or phone (312) 280-1156 after 6 pm.

**CERTIFIED PHYSICIAN'S ASSISTANT** with excellent medical, research and administrative background and experience. Available for Chicago or suburbs. Reply Box 934, c/o Illinois Medical Journal, 55 E. Monroe, Chicago, IL 60603.

## MISCELLANEOUS

**REAL ESTATE MANAGEMENT:** You are a professional but are you a professional landlord? We are Professional Landlords who can manage your property completely so that you can devote full time to your profession. If you own apartment complexes, office buildings or shopping centers, our management skills can reduce your expenses and maximize your cash flow. COMBINED CAPITAL ASSOC., Suite 2015 Tribune Tower, 435 No. Michigan Ave., Chicago, IL 60611. Tel. (312) 337-6655.

## GUARANTY FUND CERTIFICATE

**GUARANTY FUND CERTIFICATE:** Class 8 Inter-Insurance Exchange Certificate for sale (previously class 5). Call 266-1977, 9-5 P.M.

**GUARANTY FUND CERTIFICATE** for sale at discount. Phone (312) 579-0133.

**ILLINOIS STATE MEDICAL INTER-INSURANCE EXCHANGE** Guaranty Fund Certificate for sale. Territory 1 Class 1—Purchase price $772. Best offer. Please contact Mrs. Burton at 388-8052.

**GUARANTY FUND CERTIFICATE** issued by the Illinois State Medical Inter-Insurance Exchange for sale. Coverage $100,000/$300,000. Original purchase price $6,024.00. Interested call (312) 963-8777 or 920-8792.

**GUARANTY FUND CERTIFICATE**—Anesthesiologist relocating, Class 5, 1,000,000/1,000,000 coverage. Original price 10,000—purchase price 8000.00 or best offer. Favorable conditions may be arranged. Send inquiries to Box 922, c/o IMJ, 55 E. Monroe, Suite 3510, Chicago, 60603.

**GUARANTY FUND CERTIFICATE** for sale. This certificate is worth $3096 toward your purchase of any Class III, IV or V certificate. Will discount price. Call evenings 312-293-1993.

**FOR SALE:** Illinois Medical Inter-Insurance Exchange Guaranty Fund Certificate, 100,000/300,000, Class 1, Terr. I. Cost 1977, one thousand-thirty two dollars ($1032.00). Contact: Hans F. Waecker, D.O., 5200 S. Ellis Ave., Chicago 60615.

**GUARANTY FUND CERTIFICATE:** Wanted to purchase-Guaranty Fund Certificates for the Illinois State Medical Inter Insurance Exchange—call (312) 423-4499.

**GUARANTY FUND CERTIFICATE** for Territory II, Class 3—amount $2572.00—for sale. Please contact: V. J. Kelly, M.D., Cisco Lake Road, Watersmeet, MI 49969; (906) 358-4640.

**GUARANTY FUND CERTIFICATE** for sale. Class 5, Territory II, Original Cost $4792.00. Coverage: $100,000/300,000. Asking price: $3,000, negotiable. Contact Dr. Ignacio A. Chaves, 108 Crass St., Dongola, IL 62926; (618) 827-4488.

**GUARANTY FUND CERTIFICATE,** No. 214, Illinois State Medical Inter-Insurance Exchange. Contact James R. Hastings, Executor, Estate of James W. Hastings, M.D., 301 NW 2nd Street, Aledo, Illinois 61231. Phone 309-582-5388.

**GUARANTY FUND CERTIFICATE** for sale: Class 5, territory II for $1,000,000/$1,000,000 coverage, purchase price $6,024.00. For sale for $4,500.00. For information call (816) 364-5255, or write to Professional Anesthesia Services, Inc., 416 North Seventh, St. Joseph, MO 64501.

*IMJ and ISMS are not acting as brokers or agents; this is provided as a membership service.*

# *ISMS Travel Program*

Only one of the ISMS travel programs scheduled for 1978 remains open for reservations: the West Indies Air/Sea Christmas Cruise (Dec. 19-27, 1978). Information on the 1979 programs will appear in the next issue.

Descriptive brochures will be mailed five months in advance. Reservations cannot be accepted without the official form printed in these brochures. Individuals outside a member's immediate family will be placed on standby status until all ISMS members have had reasonable time to make reservations. *Promotional expenses connected with these programs are paid for by the tour operator.* For further information, contact ISMS headquarters.

# ISMS Guide to Continuing Medical Education

Compiled for Illinois physicians by the
ILLINOIS COUNCIL ON CONTINUING MEDICAL EDUCATION
55 E. Monroe St., Suite 3510 • Chicago, IL 60603 • (312) 236-6110

*Items for this Calendar must be received 90 days prior to the event. Those received earlier may appear in up to three monthly issues.*

*WARNING! Items for this Calendar come from many sources, often far in advance of the publication date. Sometimes, cancellations or changes in date, place or time occur too late to be corrected before publication. You are urged to contact the sponsoring organization to confirm information given below.*

## SEPTEMBER

### *Anesthesiology*

**EKG FOR ANESTHESIOLOGISTS**
**For:** Anesthesiologists. Lecture, beginning Sept. 18, Chicago. **Speaker:** Alon P. Winnie, M.D. **Sponsor:** Cook County Graduate School of Medicine, 707 South Wood St., Chicago 60612.. **Fee:** $225. **Reg. limit:** 35. **CME Credit:** AMA Category 1, 35 hours. **Contact:** Robert Baker, M.D. **Phone:** 312-733-2800.

### *Dermatology*

**SPECIALTY REVIEW COURSE IN DERMATOLOGY**
**For:** Dermatologists. Lecture, beginning Sept. 25, Chicago. **Speaker:** Marshall Blankenship, M.D. **Sponsor:** Cook County Graduate School of Medicine, 707 South Wood St., Chicago 60612. **Fee:** $225. **Reg. limit:** 75. **CME Credit:** AMA Category 1, 35 hours. **Contact:** Robert Baker, M.D. **Phone:** 312-733-2800.

### *Family Practice*

**ESSENTIALS OF ELECTROCARDIOGRAPHY**
**For:** Family Practitioners. Lecture, beginning Sept. 18, Chicago. **Speaker:** Kenneth Rosen, M.D. **Sponsor:** Cook County Graduate School of Medicine, 707 South Wood St., Chicago 60612. **Fee:** $225. **Reg. limit:** 50. **CME Credit:** AAFP Prescribed, 35 hours; AMA Category 1, 35 hours. **Contact:** Robert Baker, M.D. **Phone:** 312-733-2800.

### *Infectious Disease/Urology*

**21ST MEDICAL/SURGICAL SEMINAR FOR LAKE COUNTY**
**For:** M.D.'s, D.D.S.'s, R.N.'s, Rh.P.'s Seminar, September 20, 8:00 AM-1:00 PM, Waukegan, IL **CME credit:** AAFP Elective, 5 hours; AMA Category 1, 5 hours. **Reg. deadline:** 9/20. **Reg. limit:** none. **Fee:** $2.50, staff; $5.00, non-staff. **Sponsor:** St. Therese Hospital, 2615 Washington, Waukegan, IL 60085. **Contact:** R. M. Adelman. **Telephone:** 312-688-5800.

### *Internal Medicine*

**OBESITY AND DIABETES—A PERPLEXING ODD COUPLE**
**For:** M.D.'s, residents. Lecture, Sept. 27, 11:00 a.m., Auditorium, Martha Washington Hospital, 4055 North Western Ave., Chicago 60618. **Cosponsor:** Pfizer Laboratories. **Speaker:** Karl E. Sussman, M.D., Professor of Medicine, University of Colorado, Denver. **Reg. deadline:** 9/26. **Reg. limit:** none. **Fee:** none. **CME Credit:** AAFP Elective, 1 hour; AMA Category 1, 1 hour. **Contact:** Fernando Villa, M.D. **Phone:** 312-583-9000 x 331.

### *Medical Genetics*

**2ND ANNUAL SYMPOSIUM ON MEDICAL GENETICS**
**For:** Physicians, nurses, social workers. Symposium, Sept. 15, 8:30-4:30 p.m., Springfield, IL. **Fee:** $55. **Reg. limit.** none. **CME Credit:** AAFP Elective, 5 hours; AMA Category 1, 5 hours; INA applied for. **Sponsor:** SIU School of Medicine, P.O. Box 3926, Springfield, IL 62708. **Contact:** Lorraine Stephenson. **Phone:** 217-782-7711.

### *Medicine*

**CURRENT TOPICS IN INTERNAL MEDICINE**
**For:** Internists, Family Practitioners. Lecture, beginning September 25, Chicago. **Speaker:** Sheldon Waldstein, M.D. **Sponsor:** Cook County Graduate School of Medicine, 707 South Wood St., Chicago 60612. **Fee:** $225. **Reg. limit:** 100. **CME Credit:** AMA Category 1, 40 hours. **Contact:** Robert Baker, M.D. **Phone:** 312-733-2800.

### *Neurology*

**NEUROLOGY, PART II, CLINICAL**
**For:** Neurologists, Psychiatrists. Lecture, beginning Sept. 11, Chicago. **Speaker:** Neil Allen, M.D. **Sponsor:** Cook County Graduate School of Medicine, 707 South Wood St., Chicago 60612. **Fee:** $250. **Reg. limit:** 150. **CME Credit:** AMA Category 1, 44 hours. **Contact:** Robert Baker, M.D. **Phone:** 312-733-2800.

### *Obstetrics & Gynecology*

**SPECIALTY REVIEW IN OB-GYNE**
**For:** Obstetricians, Gynecologists. Lecture, beginning Sept. 25, Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 South Wood St., Chicago 60612. **Fee:** $400. **Reg. limit:** 200. **CME Credit:** AMA Category 1, 83 hours. **Contact:** Robert Baker, M.D. **Phone:** 312-733-2800.

**DEPARTMENTAL MEETING**
**For:** Obstetricians, Gynecologists. Lecture, Sept. 1, 8:00 a.m., Evanston. **Sponsor:** St. Francis Hospital, 355 Ridge Ave., Evanston, IL 60202. **Reg. limit:** none. **CME Credit:** AMA Category 2, 1 hour. **Contact:** Mitchel Byrne, M.D. **Phone:** 312-492-6227.

**GYNECOLOGICAL LAPAROSCOPY**
**For:** Gynecologists. 3-day lecture, beginning Sept. 13, Illinois Masonic Hospital, Chicago. **Speaker:** John Barton, M.D. **Sponsor:** Cook County Graduate School of Medicine, 707 South Wood St., Chicago 60612. **Fee:** $300. **Reg. limit:** 8. **CME Credit:** AMA Category 1, 18 hours. **Contact:** Robert Baker, M.D. **Phone:** 312-733-2800.

**INFECTIONS**
**For:** Gynecologists. Lecture, Sept. 8, 8:00 a.m., St. Francis Hospital, 355 Ridge Ave., Evanston, IL 60202. **Speaker:** H. Price, M.D. **Sponsor:** St. Francis Hospital. **CME Credit:** AMA Category 2, 1 hour. **Contact:** Mitchel Byrne, M.D. **Phone:** 312-492-6227.

**GYNECOLOCICAL INFECTIONS AND USE OF ANTIBIOTICS**
**For:** Gynecologists. Lecture, Sept. 15, 8:00 a.m., St. Francis Hospital, 355 Ridge Ave., Evanston, IL 60202. **Speaker:** H. Price, M.D. **Sponsor:** St. Francis Hospital. **CME Credit:** AMA Category 2, 1 hour. **Contact:** Mitchel Byrne, M.D. **Phone:** 312-492-6227.

**HIRSUTISM AND ADRENOGENITAL SYNDROME**
**For:** Gynecologists. Lecture, Sept. 22, 8:00 a.m., St. Francis Hospital, 355 Ridge Ave., Evanston, IL 60202. **Speaker:** R. Kissel, M.D. **Sponsor:** St. Francis Hospital. **CME Credit:** AMA Category 2, 1 hour. **Contact:** Mitchel Byrne, M.D. **Phone:** 312-492-6227.

**DEPARTMENTAL MEETING**
**For:** Gynecologists. Lecture, Sept. 29, St. Francis Hospital, 355 Ridge Ave., Evanston, IL 60202. **Sponsor:** St. Francis Hospital. **CME Credit:** AMA Category 2, 1 hour. **Contact:** Mitchel Byrne, M.D. **Phone:** 312-492-6227.

### *Orthopedic Surgery, Pathology*

**A SHORT COURSE ON BONE TUMORS**
**For:** Orthopods, Pathologists. 2½ day course/workshop, Sept. 14-16, Chicago. **Sponsor:** Rush-Presbyterian-St. Luke's Medical Center, Office of Continuing Education, Academic Facility, 600 S. Paulina St., Chicago 60612. **Fee:** $300. **Reg. limit:** 60. **CME Credit:** AMA Category 1, 15 hours. **Contact:** Jeffrey Norman. **Phone:** 312-942-7095.

### *Pediatrics*

**SOLVING DIFFICULT PROBLEMS IN AMBULATORY PEDIATRICS: A MULTIDISCIPLINARY APPROACH**
**For:** Pediatricians. 3-day lecture, Sept. 21-23, The Kellogg Center for Continuing Education, MSU. **CME Credit:** AMA Category 1, 16 hours. **Contact:** Conferences and Institutes, 50 Kellogg Center, MSU, East Lansing, Michigan 48824. **Phone:** 517-355-4588.

### *Psychiatry*

**SEXUAL MEDICINE**
**For:** Psychiatrists, Neurologists. Lecture, beginning Sept. 25, Chicago. **Speaker:** Domeena Renshaw, M.D. **Sponsor:** Cook County Graduate School of Medicine, 707 South Wood Street, Chicago 60612. **Fee:** $250. **Reg. limit:** 100. **CME Credit:** AAFP Prescribed, 40 hours; AMA Category 1, 40 hours. **Contact:** Robert Baker, M.D. **Phone:** 312-733-2800.

### *Radiography*

**QUALITY ASSURANCE EVALUATION OF THE RADIATION DEPARTMENT**
**For:** Radiologists. 3-day lecture, beginning Sept. 14, Chicago. **Speaker:** Theodore Fields, M.S. **Sponsor:** Cook County Graduate School of Medicine, 707 South Wood St., Chicago 60612. **Fee:** $200. **Reg. limit:** 75. **CME Credit:** AMA Category 1, 24 hours. **Contact:** Robert Baker, M.D. **Phone** 312-733-2800.

### *Surgery*

**FIBEROPTIC ESOPHAGOGASTRIC ENDOSCOPY**
**For:** Surgeons, Internists. Lecture, beginning Sept. 18, Chicago. **Speaker:** C. Thomas Bombeck, M.D. **Sponsor:** Cook County Graduate School of Medicine, 707 South Wood St., Chicago 60612. **Fee:** $300. **Reg. limit:** 15. **CME Credit:** AMA Category 1, 19 hours. **Contact:** Robert Baker, M.D. **Phone:** 312-733-2800.

**FIBEROPTIC COLONOSCOPY**
**For:** Surgeons, Internists, Family Practitioners. 3-day lecture, beginning Sept. 13, Chicago. **Speaker:** Herand Abcarian, M.D. **Sponsor:** Cook County Graduate School of Medicine, 707 South Wood St., Chicago 60612. **Fee:** $300. **Reg. limit:** 15. **CME Credit:** AMA Category 1, 19½ hours. **Contact:** Robert Baker, M.D. **Phone:** 312-733-2800.

**TREATMENT OF THE INJURED HAND**
**For:** Surgeons. 1-day course, Sept. 9, Chicago. **Sponsor:** Rush-Presbyterian-St. Luke's Medical Center, Office of Continuing Education, 600 South Paulina St., Chicago 60612. **Fee:** resident, $50; Rush Network physician, $80; other physician, $100. **CME Credit:** AMA Category 1, 7 hours. **Contact:** Office of Continuing Education. **Phone:** 312-942-7095.

**MICROSURGICAL WORKSHOP**
**For:** Surgeons. 1-day workshop, Sept. 8 or Sept. 10, Chicago. **Speaker:** Robert Schenck, M.D., Associate Professor and Director, Hand Surgery Section. **Sponsor:** Rush-Presbyterian-St. Luke's Medical Center, Office of Continuing Education, 600 South Paulina St., Chicago 60612. **Fee:** $125. **CME Credit:** AMA Category 1, 8 hours. **Contact:** Mrs. Woodfork. **Phone:** 312-942-7095.

## OCTOBER

### *Allergy*

**IMMUNOLOGIC INJURY**
**For:** Family Practitioners, Allergists. Lecture, Oct. 18, 2:00 p.m., Itasca Country Club. **Speaker:** Chester R. Zeiss Jr., M.D., Asst. Professor of Medicine, Northwestern University Medical School. **Sponsor:** DuPage County Medical Society, 26 W. St. Charles Road, Lombard, IL 60148. **Reg. deadline:** 10/16. **Fee:** none. **Reg. limit:** none. **CME Credit:** AAFP Elective, 2 hours; AMA Category 1, 2 hours. **Contact:** Lillian Widmer. **Phone:** 312-495-4050.

### *Biomed*

**FOURTH ANNUAL MEDICAL PHOTOGRAPHY WORKSHOP**
**For:** all physicians. 1-day symposium/workshop, October 28, Springfield, IL. **Sponsor:** SIU School of Medicine, P.O. Box 3926, Springfield, IL 62708. **CME Credit:** AAFP Elective, 6 hours; AMA Category 1, 6 hours. **Reg. limit:** none. **Contact:** Lorraine Stephenson. **Phone:** 217-782-7711.

### *Diabetes*

**RECENT ADVANCES IN DIABETES**
**For:** residents and attending staff. Lecture, October 25, 11:00 a.m. (lunch follows), Martha Washington Hospital, 4055 N. Western, Chicago, IL 60618. **Speaker:** Arthur H. Rubenstein, M.D., Professor and Associate Chairman, Dept. of Medicine, The University of Chicago. **CME Credit:** AAFP Elective, 1 hour; AMA Category 1, 1 hour. **Fee:** none. **Reg. limit:** none. **Reg. deadline:** 10/24. **Sponsor:** Martha Washington Hospital. **Contact:** Fernando Villa, M.D. **Phone:** 312-583-9000 x 331.

*Internal Medicine, Family Practice, Pediatrics*

**CLINICAL ALLERGY FOR PRACTICING PHYSICIANS**
For: Physicians. 3-day symposium, October 5-7, St. Louis, MO. Sponsor: Continuing Medical Education, Washington University School of Medicine, Box 8063, 660 S. Euclid, St. Louis, MO 63110. CME Credit: AAFP Elective, 16 hours; AMA Category 1, 16 hours; AOA, 16 hours. Fee: $150. Reg. limit: 150. Contact: Loretta Giacoletto. Phone: 314-454-3873.

*Internal Medicine*

**CLINICAL & LABORATORY DIAGNOSIS OF HEMORRHAGIC & THROMBOTIC DISORDERS**
For: Internists, Hematologists. Lecture, beginning Oct. 20, Chicago. Speaker: Hau C. Kwaan, M.D. Sponsor: Cook County Graduate School of Medicine, 707 South Wood St., Chicago 60612. Fee: $150. Reg. limit: none. CME Credit: AMA Category 1, 16 hours. Contact: Robert Baker, M.D. Phone: 312-733-2800.

*Medical Photography*

**FOURTH ANNUAL MEDICAL PHOTOGRAPHY WORKSHOP**
For: M.D.'s, office staff. 1-day workshop, Oct. 28, Springfield, IL. Sponsor: SIU School of Medicine, 801 N. Rutledge, P.O. Box 3926, Springfield, IL. Fee: $55-pre. Reg. limit: none. CME Credit: AMA Category 1, 6 hours. Contact: Lorraine Stephenson. Phone: 217-782-7711.

*Medicine and Surgery*

**MEDICAL AND SURGICAL APPROACHES TO ACUTE COLON AND RECTAL DISEASES**
For: Physicians. Symposium, October 26, Hillsboro, IL. Sponsor: SIU School of Medicine, P.O. Box 3926, Springfield, IL 62708. CME Credit: AAFP Elective, 4 hours; AMA Category 1, 4 hours. Reg. limit: none. Contact: Lorraine Stephenson. Phone: 217-782-7711.

*Neurology*

**NEUROLOGY UPDATE**
For: Physicians. Symposium, October 7, Pittsfield, IL. Sponsor: SIU School of Medicine, P.O. Box 3926, Springfield, IL 62708. CME Credit: AAFP Elective, 4 hours; AMA Category 1, 4 hours. Reg. limit: none. Contact: Lorraine Stephenson. Phone: 217-782-7711.

*Neurotology*

**CLINICAL NEUROTOLOGY**
For: Otologists, Neurotologists. 4-day course, October 16-19, Chicago, IL. Speaker: Nicholas Torok, M.D. Sponsor: Dept. of Otolaryngology, ALS.M., Illinois Eye & Ear Infirmary, Neurotology Section, 1855 W. Taylor, Chicago, IL 60612. Cosponsor: American Neurotology Society. CME Credit: AMA Category 1, 28 hours. Fee: $300. Contact: Nicholas Torok, M.D. Phone: 312-996-6517.

*Obstetrics & Gynecology*

**RECERTIFICATION REVIEW IN OB-GYN**
For: Obstetricians, Gynecologists. Lecture, beginning Oct. 30, Chicago. Sponsor: Cook County Graduate School of Medicine, 707 South Wood St., Chicago 60612. Fee: $225. Reg. limit: none. CME Credit: AMA Category 1, 40 hours. Contact: Robert Baker, M.D. Phone: 312-733-2800.

*Orthopaedics*

**MANAGEMENT OF COMMON FRACTURES**
For: Family Practitioners. Lecture, beginning Oct. 23, Chicago. Speaker: Peter Altner, M.D. Sponsor: Cook County Graduate School of Medicine, 707 South Wood St., Chicago 60612. Fee: $225. Reg. limit: 50. CME Credit: AAFP Prescribed, 35 hours; AMA Category 1, 35 hours. Contact: Robert Baker, M.D. Phone: 312-733-2800.

*Psychiatry*

**DISTINGUISHED LECTURE SERIES**
For: Psychiatrists, mental health professionals. lecture, Oct. 18, 8:00 p.m., Offield Auditorium, Passavant Pavilion, 303 E. Superior, Chicago. Speaker: Daniel Offer, M.D., Professor of Psychiatry, U of C. Sponsor: Institute of Psychiatry, Northwestern Memorial Hospital and Dept. of Psychiatry and Behavioral Sciences, NUMS. Reg. limit: none. CME Credit: AMA Category 1, 1½ hours. Fee: none. Contact: Leon Diamond. Phone: 312-649-8058.

**GENERAL PSYCHIATRY STUDY GROUP**
For: Psychiatrists. study group, 1st Sat. of mo., 9:00 a.m.-12:00 noon, Institute of Psychiatry, 320 E. Huron, Rm. 2011, Chicago. Sponsor: Institute of Psychiatry, Northwestern Memorial Hospital and Dept. of Psychiatry and Behavioral Sciences, NUMS. Reg. limit: 20. Fee: $150. CME Credit: AMA Category 1, 24 hours. Reg. deadline: 9/30. Contact: Leon Diamond. Phone: 312-649-8058.

**PSYCHOANALYTIC STUDY GROUP**
For: Psychiatrists. Study group, 3rd Sat. of m., 9:00 a.m.-12:00 noon, Institute of Psychiatry, 320 E. Huron, Rm. 2011, Chicago. Sponsor: Institute of Psychiatry, Northwestern Memorial Hospital and Dept. of Psychiatry and Behavioral Sciences, NUMS. Reg. limit: 20. Fee: $150. CME Credit: AMA Category 1, 24 hours. Reg. deadline: 9/30. Contact: Leon Diamond. Phone: 312-649-8058.

**RECENT ADVANCES IN PSYCHIATRY**
For: Psychiatrists. Lecture, beginning Oct. 23, Chicago. Speaker: Domeena Renshaw, M.D. Sponsor: Cook County Graduate School of Medicine, 707 South Wood St., Chicago 60612. Fee: $225. Reg. limit: 125. CME Credit: AMA Category 1, 40 hours. Contact: Robert Baker, M.D. Phone: 312-733-2800.

*Psychiatry*

**ILLINOIS PSYCHIATRIC SOCIETY 5th ANNUAL FALL WEEKEND MEETING**
For: Psychiatrists, other physicians. 3-day lecture/workshop, October 6-8, Hyatt Regency O'Hare, Chicago, IL. Sponsor: Illinois Psychiatric Society, 55 E. Monroe, Suite 3510, Chicago, IL 60603. CME Credit: AMA Category 1, 13.5 hours. Fee: $35. Reg. limit: none. Reg. deadline: 9/25. Contact: Wendy Smith. Phone: 312-782-1654.

*Radiology*

**DIAGNOSTIC IMAGING OF THE GASTROINTESTINAL TRACT**
For: Radiologists. 4-day course, Oct. 12-15, Lake of the Ozarks, MO. Sponsor: American College of Radiology. Fee: $225. CME Credit: AMA Category 1, 13 hours. Contact: Walter Whitehouse, M.D., Dept. of Rad., U of Michigan Hospital, Ann Arbor, Michigan 48109.

*Surgery*

**SPECIALTY REVIEW IN GENERAL SURGERY, PART I**
For: Surgeons. Lecture, beginning Oct. 23, Chicago. Speaker: Robert Baker, M.D. Sponsor: Cook County Graduate School of Medicine, 707 South Wood St., Chicago 60612. Fee: $425. Reg. limit: 400. CME Credit: AMA Category 1, 94 hours. Contact: Robert Baker, M.D. Phone: 312-733-2800.

*Surgery*

**CLINICAL CONGRESS**
For: Physicians. 5-day lecture, October 16-20, San Francisco, CA. Sponsor: American College of Surgeons, 55 E. Erie, Chicago, IL 60611. CME Credit: AMA Category 1. Contact: Ginny Clark. Phone: 312-664-4050.

# *NOVEMBER*

*Anesthesia*

**REGIONAL ANESTHESIA**
For: Anesthesiologists. Lecture, beginning Nov. 13, Chicago. Speakers: Vincent Collins, M.D. Sponsor: Cook County Graduate School of Medicine, 707 South Wood St., Chicago 60612. Fee: $325. Reg. limit: 10. CME Credit: AMA Category 1, 40 hours. Contact: Robert Baker, M.D. Phone: 312-733-2800.

*Family Medicine*

**MANAGEMENT OF THE ACUTE CARDIAC PATIENT**
For: Family Practitioners. Lecture, beginning Nov. 29, Chicago. Speaker: Kenneth Rosen, M.D. Sponsor: Cook County Graduate School of Medicine, 707 South Wood St., Chicago 60612. Fee: $175. Reg. limit: 75. CME Credit: AMA Category 1, 21 hours. Contact: Robert Baker, M.D. Phone: 312-733-2800.

*Internal Medicine*

**RESPIRATORY DISEASE**
For: M.D.'s. Symposium, Nov. 30, Jacksonville, IL Sponsor: SIU School of Medicine, P.O. Box 3926, Springfield, IL 62708. Reg. limit: none. CME Credit: AAFP Elective, 4 hours; AMA Category 1, 4 hours. Contact: Lorraine Stephenson. Phone: 217-782-7711.

**CHRONIC OBSTRUCTIVE PULMONARY DISEASE**
For: M.D.'s. Symposium, Nov. 8, Harrisburg, IL. Sponsor: SIU School of Medicine, P.O. Box 3926, Springfield, IL 62708. Reg. limit: none. CME Credit: AMA Category, 1, 4 hours; AAFP Elective. 4 hours. Contact: Lorraine Stephenson. Phone: 217-782-7711.

**BLOOD GASES-ELECTROLYTE IMBALANCE-HYPERALIMENTATION**
For: M.D.'s. Symposium, Nov. 4, Highland, IL. Sponsor: SIU School of Medicine, P.O. Box 3926, Springfield, IL 62708. Reg. limit: none. CME Credit: AMA Category 1, 4 hours; AAFP Elective, 4 hours. Contact: Lorraine Stephenson. Phone: 217-782-7711.

**6TH ANNUAL WEBER MEDICAL CLINIC**
For: M.D.'s. Clinic, Nov. 4, Olney, IL. Sponsor: SIU School of Medicine, P.O. Box 3926, Springfield, IL 62708. Reg. limit: none. CME Credit: AMA Category 1, 4 hours; AAFP Elective, 4 hours. Contact: Lorraine Stephenson. Phone: 217-782-7711.

**DIAGNOSIS AND TREATMENT OF ANAEROBIC INFECTIONS OF THE LUNG**
For: M.D.'s, residents. Lecture, Nov. 15, 11:00 a.m., Auditorium, Martha Washington Hospital, 4055 North Western Ave., Chicago 60618. Speaker: Haragopal Thadepalli, M.D., Martin Luther King, Jr. General Hospital, Los Angeles, CA. Reg. deadline: 11/14. Fee: none. CME Credit: AMA Category 1, 1 hour; AAFP Elective, 1 hour. Contact: Fernando Villa, M.D. Phone: 312-583-9000 ext. 331.

*Internal Medicine, Family Medicine*

**EMERGENCY CARDIOLOGY—DIAGNOSIS AND THERAPY**
For: M.D.'s. Symposium, Nov. 30-Dec. 1, St. Louis, MO. Sponsor: Continuing Medical Education, Washington University School of Medicine, Box 8063, 660 S. Euclid, St. Louis, MO 63110. Fee: $120. Reg. limit: 150. CME Credit: AMA Category 1, 12 hours; AAFP Elective, 12 hours. Contact: Loretta Giacoletto. Phone: 314-454-3873.

*Medicine*

**ADVANCES IN MEDICINE**
For: Internists. Lecture, beginning Nov. 13, Chicago. Speaker: Sheldon Waldstein, M.D. Sponsor: Cook County Graduate School of Medicine, 707 South Wood St., Chicago 60612. Fee: $225. Reg. limit: 100. CME Credit: AMA Category 1, 35 hours. Contact: Robert Baker, M.D. Phone: 312-733-2800.

*Neurology*

**RECENT ADVANCES IN NEUROLOGY**
For: Neurologists. Lecture, beginning Nov. 13, Chicago. Speaker: Neil Allen, M.D. Sponsor: Cook County Graduate School of Medicine, 707 South Wood St., Chicago 60612. Fee: $225. Reg. limit: 75. CME Credit: AMA Category 1, 40 hours. Contact: Robert Baker, M.D. Phone: 312-733-2800.

*Obstetrics & Gynecology*

**ADVANCES IN OBSTETRICS & GYNECOLOGY**
For: Obstetricians, Gynecologists. Lecture, beginning Nov. 30, Chicago. Sponsor: Cook County Graduate School of Medicine, 707 South Wood St., Chicago 60612. Fee: $175. Reg. limit: 100. CME Credit: AMA Category 1, 24 hours. Contact: Robert Baker, M.D. Phone: 312-733-2800.

**OB/GYN IN GENERAL PRACTICE**
For: M.D.'s. Symposium, Nov. 16, Mt. Vernon, IL. Sponsor: SIU School of Medicine, P.O. Box 3926, Springfield, IL 62708. Reg. limit: none. CME Credit: AMA Category 1, 4 hours; AAFP Elective, 4 hours. Contact: Lorraine Stephenson. Phone: 217-782-7711.

**MANAGEMENT OF HIGH RISK OBSTETRICAL & NEWBORN PROBLEMS**
For: Obstetricians, Pediatricians. Lecture, beginning Nov. 13, Chicago. Sponsor: Cook County Graduate School of Medicine, 707 South Wood St., Chicago 60612. Fee: $250. Reg. limit: 100. CME Credit: AMA Category 1, 50 hours. Contact: Robert Baker, M.D. Phone: 312-733-2800.

*Ophthalmology*

**CLINICAL UPDATE IN GLAUCOMA AND CORNEAL AND EXTERNAL DISEASE**
For: Ophthalmologists. Lecture, Nov. 9-10, Chicago. Sponsor: Dept. of Ophthalmology, U of I, 1855 W. Taylor, Chicago 60612. Fee: $150. Reg. limit: 60. CME Credit: AMA Category 1. Contact: Carmen Carrasco. Phone: 312-996-8023.

*Orthopedics*

**RHEUMATOLOGY AND JOINT RECONSTRUCTION**
For: M.D.'s. Symposium, Nov. 9, Quincy, IL. Sponsor: SIU School of Medicine, P.O. Box 3926, Springfield, IL 62708. Reg. limit: none. CME Credit: AMA Category 1, 4 hours; AAFP Elective, 4 hours. Contact: Lorraine Stephenson. Phone: 217-782-7711.

**SPINAL PROBLEMS**
For: M.D.'s. Symposium, Nov. 15, Belleville, IL. Sponsor: SIU School of Medicine, P.O. Box 3926, Springfield, IL 62708. Reg. limit: none. CME Credit: AMA Category 1, 4 hours; AAFP Elective, 4 hours. Contact: Lorraine Stephenson. Phone: 217-782-7711.

*Psychiatry*

**DIAGNOSIS & MANAGEMENT OF EMOTIONAL PROBLEMS IN CHILDREN & ADULTS**
For: Family Practitioners. Lecture, beginning Nov. 20, Chicago. Speaker: Domeena Renshaw, M.D. Sponsor: Cook County Graduate School of Medicine, 707 South Wood St., Chicago, 60612. Fee: $150. Reg. limit: 100. CME Credit: AAFP Prescribed, 17 hours; AMA Category 1, 17 hours. Contact: Robert Baker, M.D. Phone: 312-733-2800.

*Surgery*

**SPECIALTY REVIEW IN SURGERY, PART II**
For: Surgeons. Lecture, beginning Nov. 27, Chicago. Speaker: Robert Baker, M.D. Sponsor: Cook County Graduate School of Medicine, 707 South Wood St., Chicago 60612. Fee: $425. Reg. limit: 300. CME Credit: AMA Category 1, 99 hours. Contact: Robert Baker, M.D. Phone: 312-733-2800.

*Urology*

**104TH ANNUAL MEETING OF SOUTHERN ILLINOIS MEDICAL ASSOCIATION**
For: M.D.'s. Lecture, Nov. 9, Village of Muddy, IL. Sponsor: Southern Illinois Medical Association. Cosponsor: Illinois Academy of Family Physicians. Reg. deadline: none. Fee: none. Reg. limit: none. CME Credit: AMA Category 1, 4 hours. Contact: Dale Rosenberg, M.D., Suite 3-E, 6401 W. Main St., Belleville, IL. Phone: 618-398-5600.

# The Great Laxative Escape



## COLACE®

dioctyl sodium sulfosuccinate

Colace means escape—from laxative stimulation, from laxative harshness, from laxative habit. Colace gently helps soften stools for easy, painless, unstrained elimination. It's the great laxative escape, from infancy to old age. Available in 100 and 50 mg. capsules. Syrup or liquid.

Mead Johnson

PHARMACEUTICAL DIVISION

©1978 Mead Johnson & Company

# This asthmatic isn't worried about his next breath...



## he's active
## he's effectively maintained on

# QUIBRON

Each capsule or tablespoon (15 ml) elixir contains theophylline (anhydrous) 150 mg and glyceryl guaiacolate (guaifenesin) 90 mg. Elixir: alcohol 15%

- theophylline for effective around-the-clock bronchodilator therapy
- 100% free theophylline

**Indications:** For the symptomatic relief of bronchospastic conditions such as bronchial asthma, chronic bronchitis, and pulmonary emphysema.

**Warnings:** Do not administer more frequently than every 6 hours, or within 12 hours after rectal dose of any preparation containing theophylline or aminophylline. Do not give other compounds containing xanthine derivatives concurrently.

**Precautions:** Use with caution in patients with cardiac disease, hepatic or renal impairment. Concurrent administration with certain antibiotics, i.e. clindamycin, erythromycin, troleandomycin, may result in higher serum levels of theophylline. Plasma prothrombin and factor V may increase, but any clinical effect is likely to be small. Metabolites of guaifenesin may contribute to increased urinary 5-hydroxyindoleacetic acid readings, when determined with nitrosonaphthol reagent. Safe use in pregnancy has not been established. Use in case of pregnancy only when clearly needed.

**Adverse Reactions:** Theophylline may exert some stimulating effect on the central nervous system. Its administration may cause local irritation of the gastric mucosa, with possible gastric discomfort, nausea, and vomiting. The frequency of adverse reactions is related to the serum theophylline level and is not usually a problem at serum theophylline levels below 20 $\mu$g/ml.

**How Supplied:** Capsules in bottles of 100 and 1000 and unit-dose packs of 100; Elixir in bottles of 1 pint and 1 gallon. See package insert for complete prescribing information.

Mead Johnson
PHARMACEUTICAL DIVISION

©1978 Mead Johnson & Company • Evansville, Indiana 47721 U.S.A. MJL 6-4220

# Physician Recruitment Program

*In an effort to reduce the number of towns in Illinois needing physicians, the Physician Recruitment Program and the Doctor's Job Fair, are publishing synopses in the Journal.*

*Physicians who are seeking a place to practice or who know of any out-of-state physicians seeking an Illinois residence are asked to notify the Program.*

*Any areas wishing to be listed should contact: Mrs. E. Duffy, Physician Recruitment Program, ISMS, 55 E. Monroe, Suite 3510, Chicago, 60603.*

**ARCOLA:** Wanted-American trained F.P. to join established F.P. in active practice. Must do some O.B. Guaranteed salary and benefits. Eventual partnership. Robert N. Arrol, M.D., 126 S. Locust, Arcola, 61910. (217) 268-4444, or 268-4404. (12)

**ATKINSON:** Due to recent death of town's physician, a modern clinic with all facilities is available to a family physician who wants security and a wonderful place to practice. Hammond Henry Hospital only 8 miles away. Excellent grade and high schools and near Black Hawk Junior College. 30 miles to Quad City area, 140 miles to Chicago and 60 miles from Peoria. All recreational facilities nearby. CONTACT: John W. Ellis, Mayor, Atkinson 61235. (309) 936-7566. (12)

**CHICAGO:** Opportunities Available for Family Practitioners in a single specialty clinic setting. Association as a satellite facility with a 265 bed community hospital. Opportunity to build own practice with financial assistance available. Contact: Teryl R. Filebark, 1044 N. Francisco Ave., Chicago 60622. (312) 278-8800. (9)

**CHICAGO** (desirable suburb): Older general practitioner has excellent office facilities to share with younger G.P. Objective: need help with practice. Younger man may have guarantee to take over practice in near future. Hospital staff appointment available. All replies confidential. Box MK, Physician Recruitment Program, ISMS. (9)

**ELGIN:** Psychiatrist, ¾ time position with CMHC. Provide leadership and direction of medical and psychiatric aspects of clinical program, consult with staff, provide direct service to a wide variety of patients. Experience: past residency, preferably Board certified. Resume and salary requirements would be helpful to: Jack Crook, Director of Programs, Fox Valley Mental Health Center, 384 Division, Elgin, 60120, (312) 695-1115. (10)

**FAIRBURY:** Population 3,500. Rural area serving a population of more than 16,000. Excellent practice opportunity for family practitioner or internist interested in family practice. Enjoy life and your practice in an area which offers excellent facilities and a personal, friendly atmosphere; join the staff of 112-bed JCAH accredited community hospital. Write: Frank Brady, Administrator, Fairbury Hospital, Fairbury, 61739, or call collect (815) 692-2346. (10)

**LISLE:** Physician needed to assist me in handling my very extensive private family practice. Salary open, good opportunity for this relationship to merge into a partnership association. CONTACT: M. Sinkovits, 4513 Lincoln Ave., Lisle 60532. (312) 968-2735. (12)

**MINIER:** General or family practitioner for rich agricultural area near Bloomington. Large practice waiting due to death of doctor. Office with X-ray and other equipment, very reasonable. Unusual opportunity. Contact: Harvey Graff, Minier 61759. (309) 392-2345 or 392-2120. (10)

**OSWEGO:** Family physician or internist to join group of four in a small town primary care clinic. Two full-service hospitals nearby. One hour west of Chicago. Dr. A. Haan, Oswego, 60543. (312) 554-8431. (11)

**OTTAWA:** Opening in fields of Internal Medicine and Family Practice with multi-specialty group of nine physicians. Community, 20,000 plus. 154 bed hospital under five years old. Latest equipment One and one-half hours from Chicago and Peoria. Near State Parks. Excellent school system. Close to Jr. College and State Universities. Salary negotiable. CONTACT: Mrs. Van Buren, Ottawa Medical Center, 313 W. Madison, Ottawa 61350. (815) 433-1010. (10)

**PEORIA:** Emergency physician—Unique opportunity to start on the ground floor with fee-for-service group in 550-bed medical center seeing 27,000 ER visits. Need career-minded physician for three 16-hour shifts per week with four weeks paid vacation. Compensation 57K with excellent corporate benefits plus incentive compensation. Flexible scheduling to allow individual pursuits in university town of 250,000 in Central Illinois. Contact: Hospital Emergency Physicians S.C., 221 Northeast Glen Oak, Peoria, 61636; phone 309-672-4974. (8)

**WAUKEGAN:** Population 67,000, northern Chicago Suburb. Newly remodeled medical center near hospital. Looking for Internist, Family Physician. Contact Washington Center, 1515 Washington St., Waukegan 60085, Y. Lee, M.D. 312-336-2221 or 729-5407. (9)

IMJ
Illinois Medical Journal

# YOUR ADVERTISERS

*Our advertisers serve the Medical Profession and support your Journal. All advertisers are approved by your Journal Committee. It will help you and your society to mention your Journal when writing them.*

## Space Representatives

United Media Associates, Inc., 16 Bruce Park Avenue, Greenwich, Conn. 06830

## Pharmaceuticals


64-66 Boehringer Ingelheim
*Catapres*

74-75 Bristol Laboratories
Div. of Bristol-Myers Co.
*Tegopen*

Cover 2 Burroughs Wellcome Co.
*Neosporin*

76 Eli Lilly and Company
*Darvon*

113-114 Mead Johnson Laboratories
*Colace*
*Quibron*

61-62 Roche Laboratories
Div. of Hoffman-LaRoche
*Librax*

Covers 3&4 Roche Laboratories
Div. of Hoffman-LaRoche
*Librium*

68 Smith Kline and French Labs.
Div. of SmithKline Corp.
*Dyazide*

78 Upjohn Pharmaceuticals
*Tolinase*


## Insurance


94 Medical Protective Co.
*Professional Liability Ins.*

100 Parker Aleshire and Co.
*Group Insurance*


## Services and Continuing Education


69-70 Blue Cross and Blue Shield
Report

109 Classified Advertising

84 Cook County Graduate School
*Continuing Medical Education*

77 Illinois Bell Telephone Company
*Practice Opportunity*

106 INTRAV
*West Indies Air/Sea Cruise*

111 ISMS Guide to Continuing
Medical Education

71 Jobst Laboratories
*Venous Pressure Gradient Supports*

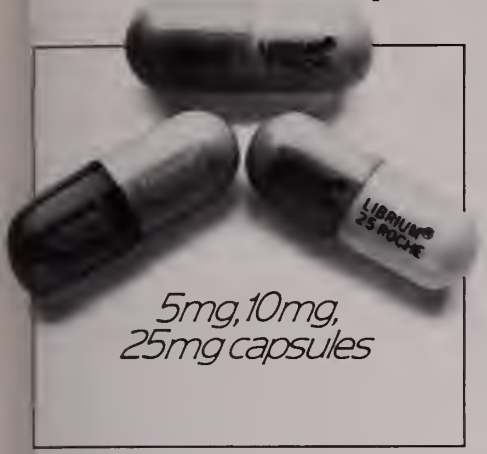
101 Mann, Levine & Weiss
*Pension Consultants*

97 Michael Reese Hospital and
Med. Cntr.
*Position Opportunity*

100 Oak Forest Hospital
*Position Opportunity*

107 S-Tek
*Data Systems*

# Librium®
## chlordiazepoxide HCl/Roche



5mg, 10mg, 25mg capsules

- ☐ Proven antianxiety performance
- ☐ An unsurpassed safety record
- ☐ Predictable patient response
- ☐ Minimal effect on mental acuity at recommended doses
- ☐ Minimal interference with many primary medications, such as antacids, anticholinergics, diuretics, cardiac glycosides and antihypertensive agents

**Before prescribing, please consult complete product information, a summary of which follows:**

**Indications:** Relief of anxiety and tension occurring alone or accompanying various disease states. Efficacy beyond four months not established by systematic clinical studies. Periodic reassessment of therapy recommended.

**Contraindications:** Patients with known hypersensitivity to the drug.

**Warnings:** Warn patients that mental and/or physical abilities required for tasks such as driving or operating machinery may be impaired, as may be mental alertness in children, and that concomitant use with alcohol or CNS depressants may have an additive effect. Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported.

**Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

**Precautions:** In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

**Adverse Reactions:** Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

**Usual Daily Dosage:** Individualize for maximum beneficial effects. Oral—Adults: Mild and moderate anxiety and tension, 5 or 10 mg t.i.d. or q.i.d.; severe states, 20 or 25 mg t.i.d. or q.i.d. Geriatric patients: 5 mg b.i.d. to q.i.d. (See Precautions.)

**Supplied:** Librium® (chlordiazepoxide HCl) Capsules, 5 mg, 10 mg and 25 mg—bottles of 100 and 500; Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10; Prescription Paks of 50, available singly and in trays of 10. Libritabs® (chlordiazepoxide) Tablets, 5 mg, 10 mg and 25 mg—bottles of 100 and 500. With respect to clinical activity, capsules and tablets are indistinguishable.

# synonymous with relief of anxiety

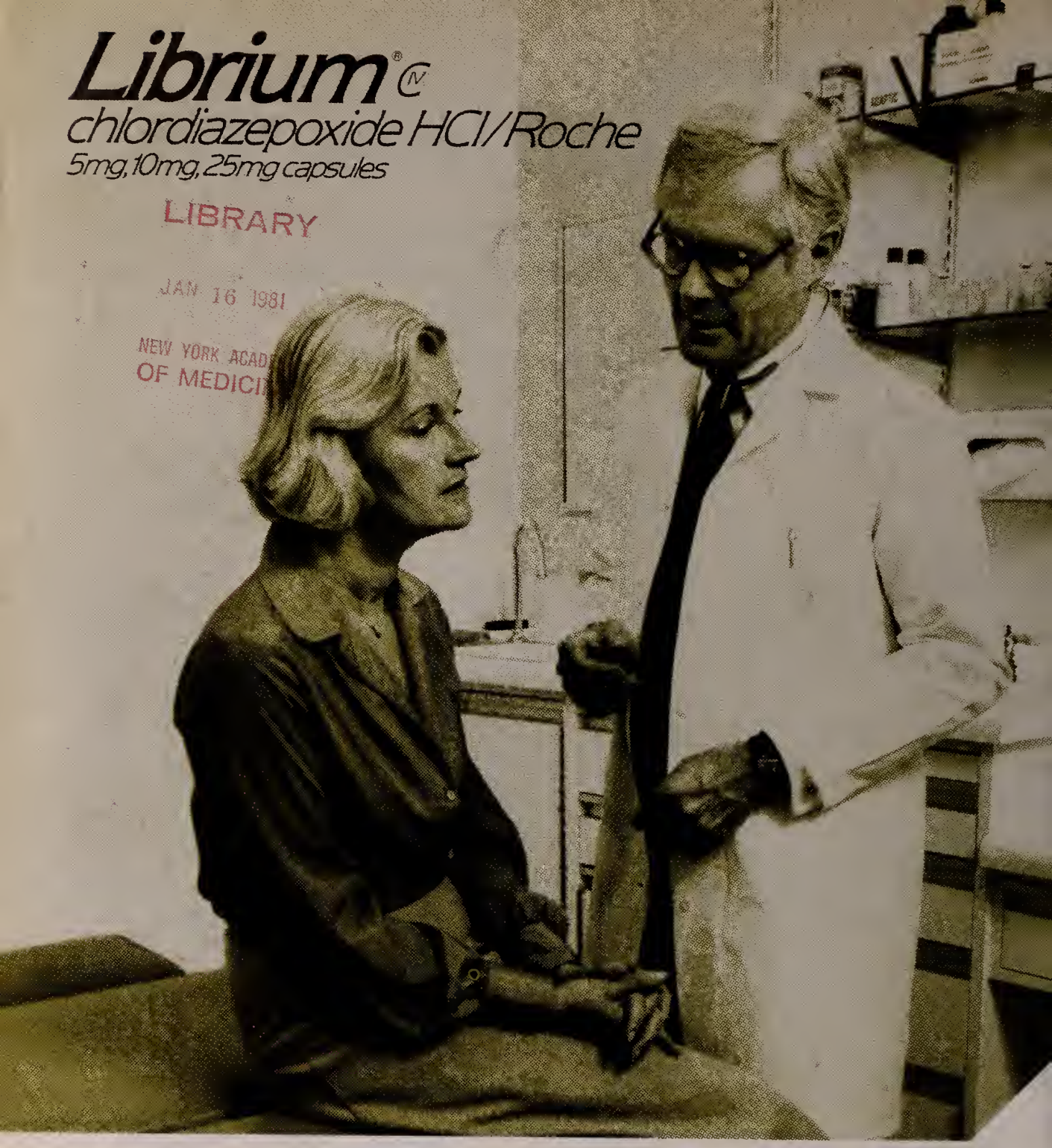
ROCHE

Roche Products Inc.
Manati, Puerto Rico 00701

Please see following page.

# Librium®
chlordiazepoxide HCl/Roche
5mg, 10mg, 25mg capsules

LIBRARY
JAN 16 1981
NEW YORK ACAD
OF MEDICI



synonymous with relief of anxiet

ROCHE

Please see preceding page for a summary of product information.

# Illinois Medical Journal

OFFICIAL JOURNAL OF THE ILLINOIS STATE MEDICAL SOCIETY

September, 1978 Volume 154, No. 3


BALCONY

**ved Hemolytic**
**fusion Reaction**
case report and
ature review
usses known clinical
ings, pertinent
oratory indicators
related problems
iagnosis and
tment ... 135

**Non-Cardiac Creatine Phosphokinase Activity Elevation**
CPK activity can play an important diagnostic role in myocardial injury, as well as skeletal muscle and neurologic disorders. Isoenzymes have been used to localize the organ system of involvement. This case report presents some evaluative criteria ... 138

**The Comprehensive Program for Children with Epilepsy**
This service is designed for physicians treating childhood epilepsy who seek experienced consultation. Pediatric neurologists are now available to provide this through the CPCE toll-free telephone number ... 140

K045-01-34-003-5-162
WM JAMES BALL MD
433 S COMMONWEALTH
AURORA ILL
60506
09074

le of Contents 117
sident's Page 160



# EMPIRIN® COMPOUND
# with CODEINE

[illegible] C-III

Burroughs Wellcome Co.
Research Triangle Park
[illegible]

IMJ

Illinois Medical Journal

SEPTEMBER, 1978 Vol. 154, No. 3 CONTENTS

120 Abstracts of Board of Trustees Action

*Clinical Articles*

135 Delayed Hemolytic Transfusion Reaction
*By Bak M. Lee, M.D.*

138 Non-Cardiac Creatine Phosphokinase Activity Elevation
*By John A. Damergis, M.D., and Jerome M. Stoker, M.D.*

*Special Articles*

140 The Comprehensive Program for Children with Epilepsy
*By B. Hermann, Ph.D., E. Page-El, M.D., E. Zurbruugg, M.D., S. Chhabria, M.D., and R. Black, D.S.W.*

*Surgical Grand Rounds*

143 Case Report: Cryptorchidism
*John M. Beal, M.D., Contributing Editor*

*Seminars in Immunopathology and Oncology*
*Richard J. Albin, Ph.D., Contributing Editor*

146 Immune Complexes and Human Disease
*By Brian S. Andrews, BSc (Med.) and Ronald Penny, M.D.*

*President's Page*

160 NHI Drive Hits Snag
*David S. Fox, M.D., President*

*(Contents continued on overleaf)*

## *Features*


122 EKG of the Month
125 Clinics for Crippled Children
126 Housestaff News
129 Viewbox
142 Obituaries
154 Membership Forum
158 Physician Recruitment
161 Doctor's News
164 ICCME Calendar
170 Classified Advertising
172 Pulse of the ISMS Auxiliary
173 Index to Advertisers
169 Ask a Consultant
166 Illinois Society, American Association of Medical Assistants


## *Staff*


**Managing Editor** ..... **Richard A. Ott**
**Assistant Editor** ..... **Mariann M. Stephens**
**Executive Administrator** ..... **Roger N. White**

*(Cover by Jane and C. R. Bushwaller)*

### PUBLICATIONS COMMITTEE

Herschel Browns, M.D., Chicago, *Chairman*
Kenneth A. Hurst, M.D., Naperville
Robert P. Johnson, M.D., Springfield
Alfred J. Kiessel, M.D., Decatur
Harold J. Lasky, M.D., Chicago

### Editorial Board

J. William Roddick, Jr., M.D., Springfield, *Chairman*
Eli L. Borkon, M.D., Carbondale
Daniel R. Cunningham, M.D., Wilmette
Raymond A. Dieter, Jr., M.D., Glen Ellyn
James G. Ekeberg, M.D., Palatine
Ediz Z. Ezdinli, M.D., Kenilworth
Carl Neuhoff, M.D., Peoria
Constantine S. Soter, M.D., Arlington Heights
Donald D. VanFossan, M.D., Springfield

Contributor in Surgery: John M. Beal, M.D., Chicago
Contributor in Maternal Death Studies: Robert R. Hartman, M.D., Jacksonville
Contributor in Pediatric Perplexities: Ruth Andrea Seeler, M.D., Chicago
Contributor in Radiology: Leon Love, M.D., Maywood
Contributor in Cardiology: John R. Tobin, M.D., Maywood
Contributor in Immunopathology: Richard J. Ahlin, Ph.D., Chicago
Contributor in Rheumatology: L. F. Layfer, M.D., Chicago



### ILLINOIS STATE MEDICAL SOCIETY

#### OFFICERS

David S. Fox, M.D., President
826 E. 61st St., Chicago 60637
P. John Seward, M.D., President-Elect
310 N. Wyman St., Rockford 61101
Herschel Browns, M.D., 1st Vice-President
4600 N. Ravenswood, Chicago 60640
G. W. Giehelhausen, M.D., 2nd Vice-President
1101 Main St., Peoria 61606
Audley F. Connor, Jr., M.D., Secretary-Treasurer
7531 S. Stony Island Ave., Chicago 60649

#### HOUSE OF DELEGATES

Cyril C. Wiggishoff, M.D., Speaker
25 E. Washington, Chicago 60602
Robert P. Johnson, M.D., Vice-Speaker
108 Maple Grove, Springfield 62707

#### TRUSTEES

1st District: 1980, John J. Ring, M.D.
511 Hawley, Mundelein 60060
2nd District: 1980, Allan L. Goslin, M.D.
712 N. Bloomington, Streator 61364
3rd District: 1979, Alfred Clementi, M.D.
675 W. Central Rd., Arlington Heights 60005
3rd District: 1980, Raymond J. Des Rosiers, M.D.
1044 N. Francisco, Chicago 60622
3rd District: 1979, Robert T. Fox, M.D.
2136 Rohincrest, Glenview 60025
3rd District, 1979, Jere Freidheim, M.D.
3050 S. Wallace, Chicago 60616
3rd District: 1981, Morris T. Friedell, M.D.
7531 S. Stony Island Ave., Chicago 60649
3rd District: 1981, Henrietta Herholsheimer, M.D.
1700 E. 56th St., Chicago 60637
3rd District: 1981, Lawrence L. Hirsch, M.D.
2434 Grace St., Chicago 60618
3rd District: 1980, Harold J. Lasky, M.D.
55 E. Washington, Chicago 60602
3rd District: 1980, Richard N. Rovner, M.D.
645 N. Michigan, Suite 920, Chicago 60611
3rd District: 1980, Joseph C. Sherrick, M.D.
303 E. Superior, Chicago 60611
4th District: 1979, Fred Z. White, M.D.
723 N. Second St., Chillicothe 61523
5th District: 1979, P. F. Mahon, M.D.
800 E. Carpenter, Springfield 62702
6th District: 1981, Robert R. Hartman, M.D.
1515 A. W. Walnut, Jacksonville 62650
7th District: 1979, Alfred J. Kiessel, M.D.
1 Powers Lane Pl., Decatur 62522
8th District: 1979, James Laidlaw, M.D.
104 W. Clark, Champaign 61820
9th District: 1981, Warren D. Tuttle, M.D.
203 N. Vine St., Harrisburg 62946
10th District: 1981, Julian W. Buser, M.D.
6600 W. Main St., Belleville 62223
11th District: 1980, Kenneth A. Hurst, M.D.
52 Bunting Lane, Naperville 60540
12th District: 1980, Joseph Perez, M.D.
5670 E. State St., Rockford 61108
Trustee-At-Large: George T. Wilkins, M.D.
27 Glen Echo Dr., Edwardsville 62025
Chairman of the Board: Robert R. Hartman, M.D.
1515 A. W. Walnut, Jacksonville 62650



Microfilm copies of current as well as some back issues of the *Illinois Medical Journal* may be purchased from Xerox University Microfilm, 300 North Zeeb Road, Ann Arbor, Mich. 48106.

Contents of *IMJ* are listed in the *Current Contents/Clinical Practice.*

Published by the Illinois State Medical Society, 55 E. Monroe St., Chicago, Ill. 60603 (312-782-1654)



Copyright, 1978. The Illinois State Medical Society. All material subject to this copyright may be photocopied for the noncommercial purpose of scientific or educational advancement.



Subscription $8.00 per year, in advance, postage prepaid, for the United States, Cuba, Puerto Rico, Philippine Islands and Mexico. $10.00 per year for all foreign countries included in the Universal Postal Union. Canada $8.50. U.S. Single current copies available at $1.00 ($1.10 by mail), back issues $1.50.

Second class postage paid at Chicago, Ill. When moving please notify Journal office of new address including old mailing label with notification, if possible. POSTMASTER: Send notice on form No. 3579 to Illinois State Medical Society, 55 E. Monroe St., Chicago, Ill. 60603.

Pharmaceutical advertising must be approved by the ISMS Publications Committee. Other advertising accepted after review by Publications Committee or Board of Trustees. All copy or plates must reach the Journal office by the fifteenth of the month preceding publication. Rates furnished upon request.

Original articles will be considered for publication with the understanding that they are contributed only to the *Illinois Medical Journal.* The ISMS denies responsibility for opinions and statements expressed by authors or in excerpts, other than editorial or allied views or statements which reflect the authoritative action of the ISMS or of reports on official actions, policies or positions. Views expressed by authors do not necessarily represent those of the Society; any connection with official policies is coincidental.

The *Illinois Medical Journal* is published by the Illinois State Medical Society as an educational and professional informational magazine and distributed as a benefit of membership in the Illinois State Medical Society. Its intent is to keep members current in medical knowledge and is a part of a continuing medical education program. Socioeconomic matters, affecting as they do a changing pattern in the proper delivery of medical care, are considered an inherent element in medical education.




## VALIUM®(diazepam)

**Before prescribing, please consult complete product information, a summary of which follows:**
**Indications:** Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders; athetosis; stiff-man syndrome; convulsive disorders (not for sole therapy)
The effectiveness of Valium in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should period-

**Contraindicated:** Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.
**Warnings:** Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**
**Precautions:** If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or over-

hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice, periodic blood counts and liver function tests advisable during long-term therapy.

Roche Laboratories

# *Abstracts of Board Actions*

**August 5-6, 1978** **Chicago**

*These abstracts are published so that members of the Illinois State Medical Society may keep advised of the actions of the Board of Trustees. It covers only major actions and is not intended as a detailed report. Full minutes of the meetings are available upon any member's request to the headquarters office of the ISMS.*

## Cost of Medical Care

Guided by ISMS and AMA House of Delegates action, the Board considered recommendations of the National Commission on the Cost of Medical Care. ISMS will submit its views to the AMA Board of Trustees on those Commission recommendations referred to the AMA Board by the Association's House of Delegates. A complete report of the ISMS Board action will be presented at the Interim Session of the House of Delegates, November 4-5.

## Medical Disciplinary Board

ISMS will continue to support the state's Medical Disciplinary Board in the Board's efforts to have regulations governing its activities adhered to by the Dept. of Registration and Education. Last month, ISMS testified before the Board to voice concern over R&E practices which circumvent the Board's authority and violate the intent of the law which created the medical disciplinary system.

## Revised '78 Budget

The Board approved a revised 1978 budget of $1.7 million, reflecting a $12,364 reduction in the anticipated total budget deficit. The Board also: (1) Approved sponsorship of an AVIS car rental plan which will entitle ISMS members to a 15% discount; (2) Increased to $100 the per diem allowance for members of the AMA Delegation, paid for each day of delegate meeting attendance; and (3) Authorized a 10% increase in Illinois Medical Journal black and white advertising rates effective January 1.

## Mental Health Code

ISMS has urged Gov. Thompson to sign into law SB 250 which would revise the state's Mental Health Code. While expressing concern over some objectionable provisions of SB 250, ISMS noted that further delays in developing a new code could hinder proper care of the mentally ill.

## Medicaid

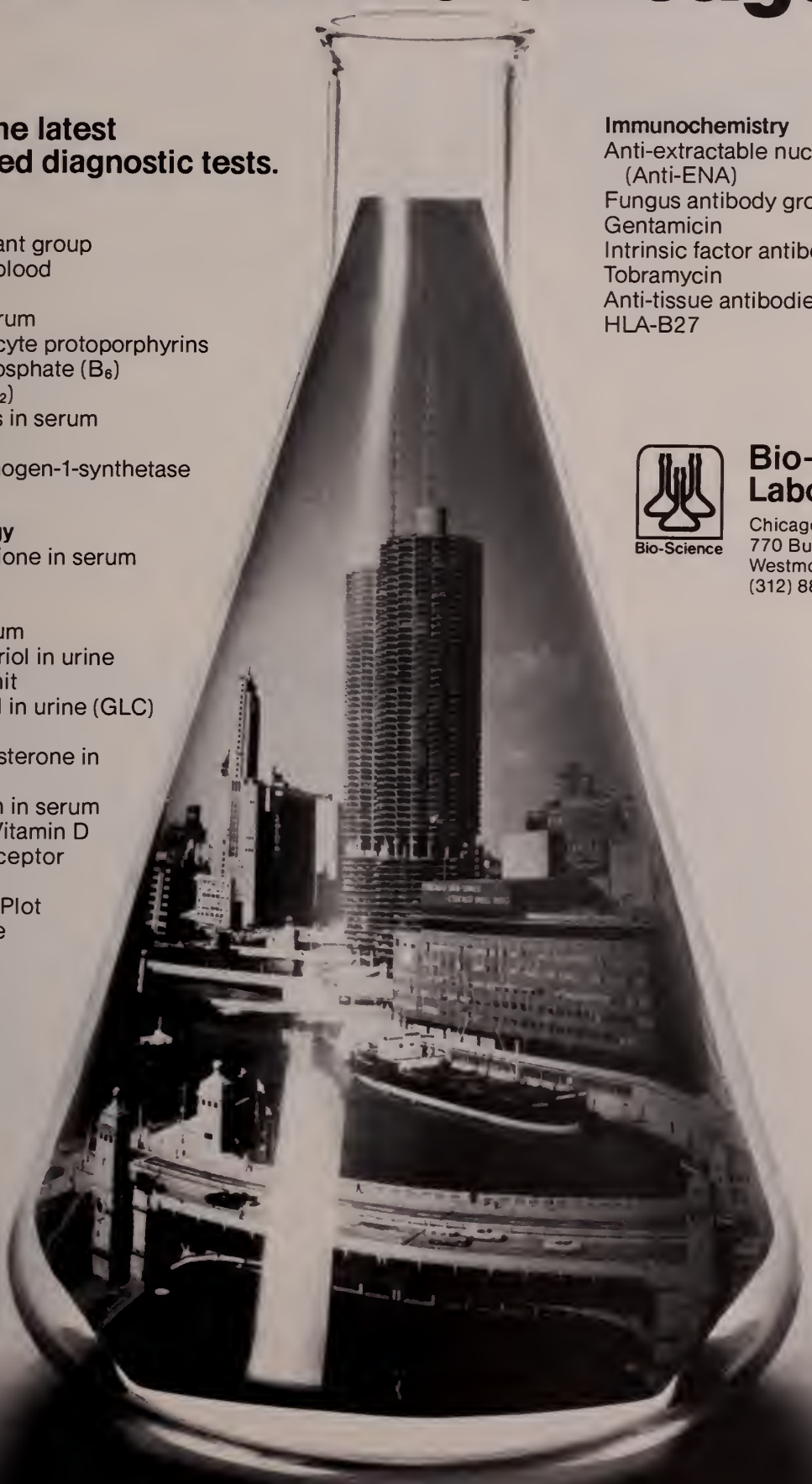
A meeting with Gov. Thompson will be requested to seek resolution of major Medicaid problems faced by Illinois physicians and suggest changes in administration of the Medicaid program. In addition, ISMS will urge members to bill Medicaid at their customary rate, not the amount paid by IDPA . . . and urge IDPA to maintain information on these customary fees, since any future fee updating should be based on actual charges, not on IDPA's current payment levels.

## National Health Insurance

ISMS again will inform the AMA Board of Trustees of the Society's opposition to National Health Insurance (NHI) and urge AMA to postpone its endorsement of any NHI legislative proposal until the 1979 AMA annual meeting. In related action, ISMS trustees voted to distribute and explain to component societies the contents of an AMA packet which reviews HR 1818 and explains the AMA's principles of comprehensive health insurance.

*(Continued on page 156)*

# What's new at Bio-Science Chicago?



## Always the latest specialized diagnostic tests.

**Chemistry**
Anti-convulsant group
Cadmium in blood
Darvon®
Ferritin in serum
Free erythrocyte protoporphyrins
Pyridoxal phosphate ($B_6$)
Riboflavin ($B_2$)
Succinimides in serum
Theophylline
Uroporphyrinogen-1-synthetase
Clonopin®

**Endocrinology**
Androstenedione in serum
Calcitonin
C-Peptide
Estriol in serum
Placental Estriol in urine
HCG-$\beta$-subunit
Pregnanetriol in urine (GLC)
Prolactin
17-OH Progesterone in serum
Thyroglobulin in serum
25-Hydroxy Vitamin D
Estradiol Receptor Assay by Scatchard Plot
Progesterone Receptor Assay

**Immunochemistry**
Anti-extractable nuclear antigen (Anti-ENA)
Fungus antibody group
Gentamicin
Intrinsic factor antibodies
Tobramycin
Anti-tissue antibodies
HLA-B27

Bio-Science

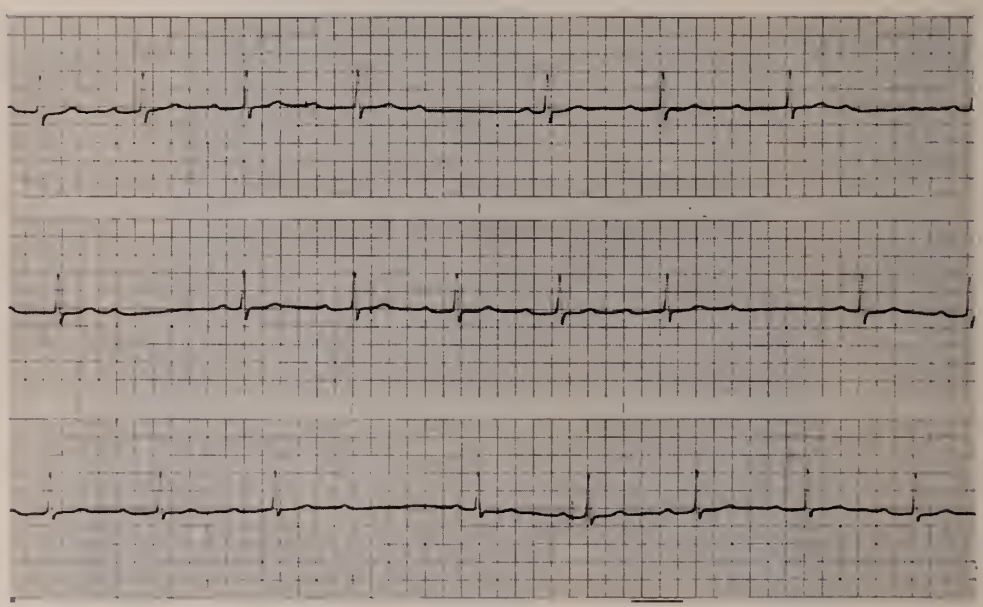
**Bio-Science Laboratories**

Chicago Branch
770 Burr Oak Drive
Westmont, Il 60559
(312) 887-9800

# ekg of the month

John F. Moran, M.S., M.D., David L. Fishman, M.D.,
Patrick J. Scanlon, M.D., Sarah A. Johnson, M.D.,
John R. Tobin, M.S., M.D., and Rolf M. Gunnar, M.S., M.D.
Section of Cardiology, Department of Medicine,
Loyola University Stritch School of Medicine

*This is a 55-year-old lady who was in good health until December when she began getting chest pains. These pains were located in the retrosternal area and were related to climbing stairs. The pains were relieved by rest. In January, her pains became more frequent and lasted longer. She came to the emergency room and was admitted to the coronary care unit. A continuous ECG rhythm strip was recorded and is shown. In the review of systems, the patient complained of gradually worsening fatigue, some constipation, dry skin, and cold intolerance. Physical examination showed a blood pressure of 110/73 mm. mercury, dry, gray hair, bilateral xanthelasma, irregular pulse, and dry, scaly skin. Serial ECGs and serum enzymes did not demonstrate a myocardial infarction. A clinical impression of hypothyroidism was confirmed by $T_3$=21% (normal, 25-35%), $T_4$=1.1 (normal = 4.0-11.0 micrograms per dilution), and a TSH greater than 48 (normal 0-10 microunits per dilution).*



## *Questions:*

1. **The ECG shows:**
   - A. Atrial fibrillation with a slow ventricular response.
   - B. Bilateral bundle branch block.
   - C. Frequent premature atrial beats.
   - D. Sinus rhythm with atrioventricular (AV) Wenckebach block.
   - E. Type I second degree AV block.
2. **Treatment for this patient should include:**
   - A. Thyroid replacement therapy given cautiously.
   - B. Propranolol.
   - C. Sublingual nitroglycerin.
   - D. Coronary arteriogram.
   - E. All of the above.

*(Continued on page 169)*

# It's what's behind our Bellboy® pocket pager that makes it different.

One pocket pager is pretty much the same as the next.

Because most pocket pagers on the market are made by a very small number of manufacturers.

So it's not so important who makes your pager as who backs it up.

When you get a Bellboy pager, you not only get an excellent piece of equipment, you get the benefits of a system nobody else offers.

A system owned and operated by Illinois Bell.

Like our automated, computerized signaling. It virtually eliminates waiting and busy signals, and makes getting through simple.

And Illinois Bell also has more transmitter towers. That means the signal beamed out to a Bellboy pager is strong and dependable. More capable of penetrating hard-to-beep places. Like basements. And elevators of downtown buildings.



And if anything should ever go wrong with your Bellboy pager, Illinois Bell will repair or replace it fast. At no additional charge.

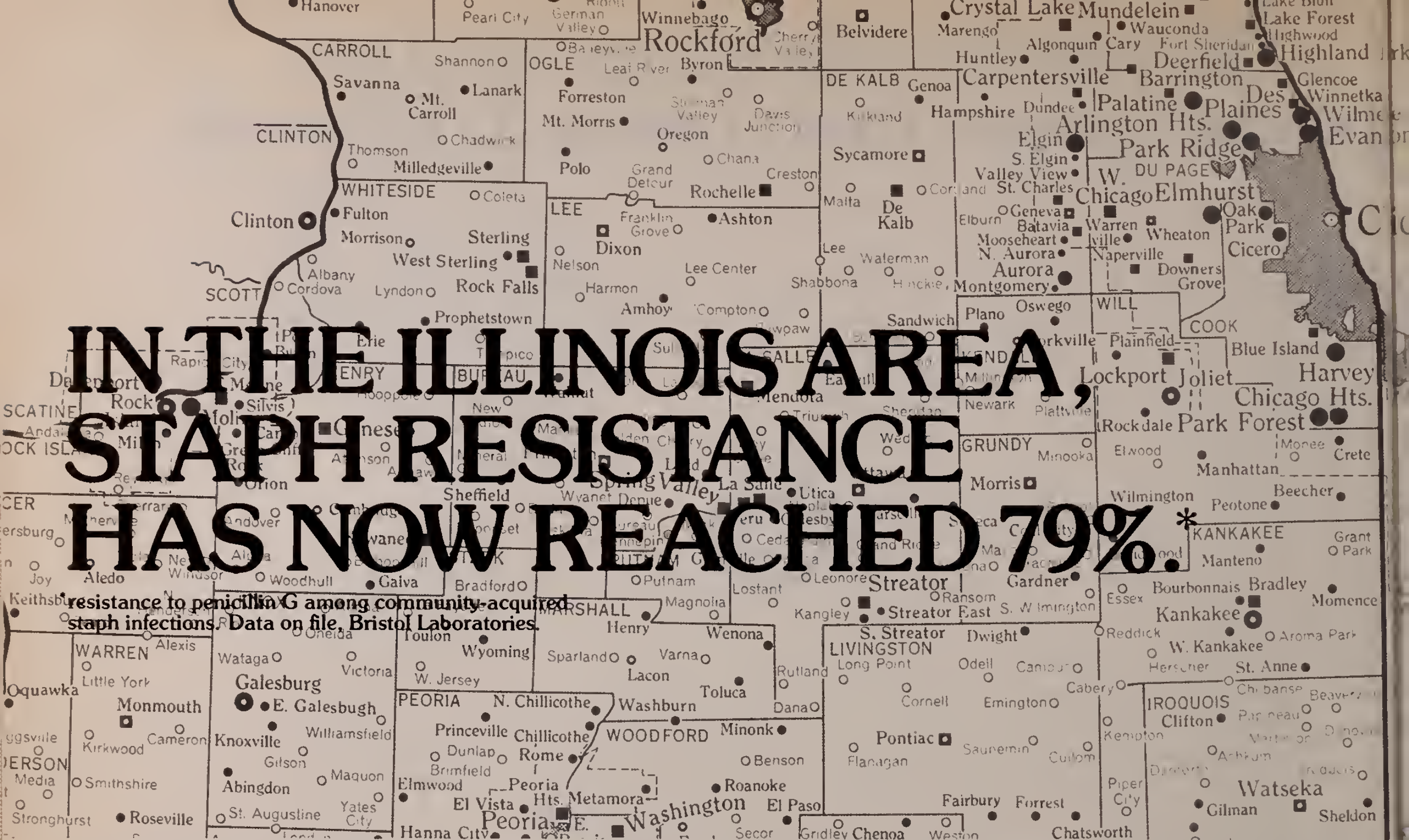
All this and basic Bellboy service still costs only $20 per month ($22 for dual-tone service)*. That's about the same monthly cost as most other pocket pagers.

Before you choose a pager, look behind the Bellboy pager. There's a lot more than meets the eye.

***To order, or for more information, call 800-972-2119. Toll-free. Today.***

*Prices plus tax. Applicable service ordering charges additional.

Illinois Bell




# IN THE ILLINOIS AREA, STAPH RESISTANCE HAS NOW REACHED 79%.*

*resistance to penicillin G among community-acquired staph infections. Data on file, Bristol Laboratories.

## WHEN YOU CAN'T RULE OUT STAPH, CONSIDER

# TEGOPEN®

# (cloxacillin sodium)

## ..."THE PENICILLIN OF TODAY"

- Effective against nonpenicillinase-producing staphylococci, beta-hemolytic streptococci, and pneumococci.†

†NOTE: The choice of Tegopen should take into consideration the fact that it has been shown to be effective only in the treatment of infections caused by pneumococci, Group A beta-hemolytic streptococci, and penicillin G-resistant and penicillin G-sensitive staphylococci. If the bacteriology report later indicates that the infection is due to an organism other than a penicillin G-resistant staphylococcus sensitive to cloxacillin sodium, the physician is advised to continue therapy with a drug other than cloxacillin sodium or any other penicillinase-resistant semisynthetic penicillin. The clinical significance of *in vitro* data is unknown.

- 10 times more active against strep than staph.

- Well absorbed from the G.I. tract.‡

‡Maximum absorption occurs when Tegopen is taken on an empty stomach, preferably 1-2 hrs. before meals.



Please see brief summary for prescribing information.

**Brief Summary of Prescribing Information**
**Combined TEGOPEN® (cloxacillin sodium)**
**Capsules and Oral Solution**
For complete information, consult Official Package Circular. (12) TEGOPEN 9/11/75

**Indications:** Although the principal indication for cloxacillin sodium is in the treatment of infections due to penicillinase-producing staphylococci, it may be used to initiate therapy in such patients in whom a staphylococcal infection is suspected. (See Important Note below.)

Bacteriologic studies to determine the causative organisms and their sensitivity to cloxacillin sodium should be performed.

**Important Note:** When it is judged necessary that treatment be initiated before definitive culture and sensitivity results are known, the choice of cloxacillin sodium should take into consideration the fact that it has been shown to be effective only in the treatment of infections caused by pneumococci, Group A beta-hemolytic streptococci, and penicillin G-resistant and penicillin G-sensitive staphylococci. If the bacteriology report later indicates the infection is due to an organism other than a penicillin G-resistant staphylococcus sensitive to cloxacillin sodium, the physician is advised to continue therapy with a drug other than cloxacillin sodium or any other penicillinase-resistant semi-synthetic penicillin.

Recent studies have reported that the percentage of staphylococcal isolates resistant to penicillin G outside the hospital is increasing, approximating the high percentage of resistant staphylococcal isolates found in the hospital. For this reason, it is recommended that a penicillinase-resistant penicillin be used as initial therapy for any suspected staphylococcal infection until culture and sensitivity results are known.

Cloxacillin sodium is a compound that acts through a mechanism similar to that of methicillin against penicillin G-resistant staphylococci. Strains of staphylococci resistant to methicillin have existed in nature and it is known that the number of these strains reported has been increasing. Such strains of staphylococci have been capable of producing serious disease, in some instances resulting in fatality. Because of this, there is concern that widespread use of the penicillinase-resistant penicillins may result in the appearance of an increasing number of staphylococcal strains which are resistant to these penicillins.

Methicillin-resistant strains are almost always resistant to all other penicillinase-resistant penicillins (cross-resistance with cephalosporin derivatives also occurs frequently). Resistance to any penicillinase-resistant penicillin should be interpreted as evidence of clinical resistance to all, in spite of the fact that minor variations in *in vitro* sensitivity may be encountered when more than one penicillinase-resistant penicillin is tested against the same strain of staphylococcus.

**Contraindications:** A history of a previous hypersensitivity reaction to any of the penicillins is a contraindication.

**Warning:** Serious and occasionally fatal hypersensitivity (anaphylactoid) reactions have been reported in patients on penicillin therapy. Although anaphylaxis is more frequent following parenteral therapy it has occurred in patients on oral penicillins. These reactions are more apt to occur in individuals with a history of sensitivity to multiple allergens.

There have been well documented reports of individuals with a history of penicillin hypersensitivity reactions who have experienced severe hypersensitivity reactions when treated with a cephalosporin. Before therapy with a penicillin, careful inquiry should be made concerning previous hypersensitivity reactions to penicillins, cephalosporins, and other allergens. If an allergic reaction occurs, the drug should be discontinued and the patient treated with the usual agents, e.g., pressor amines, antihistamines, and corticosteroids.

Safety for use in pregnancy has not been established.

**Precautions:** The possibility of the occurrence of superinfections with mycotic organisms or other pathogens should be kept in mind when using this compound, as with other antibiotics. If superinfection occurs during therapy, appropriate measures should be taken.

As with any potent drug, periodic assessment of organ system function, including renal, hepatic, and hematopoietic, should be made during long-term therapy.

**Adverse Reactions:** Gastrointestinal disturbances, such as nausea, epigastric discomfort, flatulence, and loose stools, have been noted by some patients. Mildly elevated SGOT levels (less than 100 units) have been reported in a few patients for whom pretherapeutic determinations were not made. Skin rashes and allergic symptoms, including wheezing and sneezing, have occasionally been encountered. Eosinophilia, with or without overt allergic manifestations, has been noted in some patients during therapy.

**Usual Dosage:** Adults: 250 mg. q.6h.

Children: 50 mg./Kg./day in equally divided doses q.6h. Children weighing more than 20 Kg. should be given the adult dose. Administer on empty stomach for maximum absorption.

*N.B.:* INFECTIONS CAUSED BY GROUP A BETA-HEMOLYTIC STREPTOCOCCI SHOULD BE TREATED FOR AT LEAST 10 DAYS TO HELP PREVENT THE OCCURRENCE OF ACUTE RHEUMATIC FEVER OR ACUTE GLOMERULONEPHRITIS.

**Supplied:** Capsules—250 mg. in bottles of 100, 500 mg. in bottles of 100. Oral Solution—125 mg./5 ml. in 100 ml. and 200 ml. bottles.

BRISTOL®
BRISTOL LABORATORIES
Division of Bristol-Myers Company
Syracuse, New York 13201

# Clinics for Crippled Children Listed for October

Thirty-six clinics for Illinois' physically handicapped children have been scheduled for October by the University of Illinois, Division of Services for Crippled Children. The Division will count twenty-five general clinics providing diagnostic orthopedic, pediatric, speech and hearing examination, along with medical, social and nursing services. There will be nine special clinics for children with cardiac conditions and two for children with cerebral palsy. Any private physician may refer to or bring to a convenient clinic any child or children for whom he may want examination or consultative services.

October 3 Quincy—Blessing Hospital
October 3 Park Ridge Cardiac—Lutheran General Hospital
October 4 Cairo—Public Health Department
October 4 Hinsdale—Hinsdale Sanitarium
October 5 Sterling—Community General Hospital
October 5 Lake County Cardiac—Victory Memorial Hospital
October 6 Division Cardiac—U. of I. at the Medical Center
October 9 Peoria Cardiac—St. Francis Hospital
October 10 Peoria—St. Francis Hospital
October 10 East St. Louis—Christian Welfare Hospital
October 11 Metropolis—Massac Memorial Hospital
October 11 Jacksonville—Passavant Hospital
October 11 Champaign—McKinley Hospital
October 11 Joliet—St. Joseph's Hospital
October 12 Flora—Clay County Hospital
October 12 Springfield—St. John's Hospital
October 12 Kankakee General—St. Mary's Hospital
October 13 Chicago Heights Cardiac—St. James Hospital
October 16 Maywood—Loyola Medical Center
October 17 Rock Island—Moline Public Hospital
October 17 Decatur—Decatur Memorial Hospital
October 17 Belleville—St. Elizabeth's Hospital
October 18 Centralia—St. Mary's Hospital
October 18 Springfield Ped-Neuro—St. John's Hospital
October 18 Aurora—St. Joseph Mercy Hospital
October 18 Chicago Heights General—St. James Hospital
October 19 Rockford—Swedish-American Hospital
October 19 Bloomington—Mennonite Hospital
October 19 Elmhurst Cardiac—Memorial Hospital of DuPage County
October 20 Kankakee Cardiac—St. Mary's Hospital
October 23 Peoria Cardiac—St. Francis Hospital
October 24 Peoria—St. Francis Hospital
October 24 Danville—Lake View Hospital
October 25 Elgin MM—Sherman Hospital
October 27 Chicago Heights Cardiac—St. James Hospital
October 27 Evanston—St. Francis Hospital

The Division of Services for Crippled Children is the official state agency established to provide medical, surgical, corrective and other services and facilities for diagnosis, hospitalization and after-care for children with crippling conditions or who are suffering from conditions that may lead to crippling. In carrying on its program, the Division works cooperatively with local medical societies, hospitals, the Illinois Children's Hospital-School, civic and fraternal clubs, visiting nurse associations, local social and welfare agencies, local chapters of the National Foundation and other interested groups. In all cases, the work of the Division is intended to extend and supplement, not supplant, activities of other agencies, either public or private, state or local, carried on in behalf of crippled children.

ILLINOIS HOUSESTAFF NEWS

# Report on the 1978 AMA-RPS Annual Meeting

By Linda L. Hughey, M.D./Wilmette

*This is a monthly column which welcomes contributions, comments, and questions from interested readers. Address all correspondence to Dr. Linda Hughey, c/o the Illinois Medical Journal, 55 E. Monroe, Chicago, Ill. 60603.*

## *The Fate of the Resident Page: In Whose Hands?*

Several years ago, the ISMS Board of Trustees set aside a page in the *Illinois Medical Journal* for the Resident Physician Section, with the understanding that this page was to be used for communicating items of interest to residents and news of resident activities. For more than a year after its initiation, the column appeared monthly but it then died for lack of resident interest. It was rejuvenated last November when the ISMS-Resident Physician Section again became active. The present resident page has a physical substance but lacks a character definition. Some of the columns over the past few months have evoked dramatic readership response, but certain ISMS officials have questioned whether the resident page should be allowed the freedom to include editorial material or be restricted to simple news items.

On August 5, the RPS Secretary-Editor met with the ISMS Publications Committee in an attempt to delineate editorial policy. In a lively and amicable discussion, the following agreement was reached: No specific restrictions will be made on content of the resident page, but the page will be subject to review by the Publications Committee prior to acceptance for publication. The resident page will attempt to publish items of general resident interest rather than to express one individual's viewpoint, although individual views certainly may be included in the resident page.

The fate of the page will depend finally upon you the reader. The ISMS-Resident Physician Section will respond to questions and comments about the type of information *you* would like to see in the *Journal* resident page. Please get in touch with us with news of resident activities, problems, and items of resident interest. The resident column can only be of interest if you, the residents, make it so.

**Resident Activities**

*Nov. 4-5:* ISMS Interim Meeting—includes several activities which are open to ISMS members and should be of specific interest to residents. Contact the ISMS for a schedule of meeting activities.

*Dec. 1-7:* AMA Interim meeting in Chicago. ISMS-RPS will be hosting residents from across the country; a wide number of hospitality suites and other social and educational activities will be open to resident participants. Contact the American Medical Association at 535 N. Dearborn for details and watch future columns.

**Resident Salaries and Increasing Medical Care Costs**

HEW Secretary Joseph Califano, in presenting NHI (National Health Insurance) principles, told the press that health care costs are rising, exceeding the rise in the general cost of living. Yet the Bureau of Labor statistics show the Consumer Price Index figures to indicate a 0.5% medical care cost increase in June and a 0.6% rise in April and May, while the all-items index rose 1.0% in June and 0.9% in April and May.*

How do resident salaries enter into medical care price increases? First-year residents at University of Chicago, for example, last year received $13,500 and this year receive $14,000. This $500 increase is approximately 3.6%—well below the general inflation rate of 8 to 10% annually. The ISMS Resident Physician section would like to hear from residents throughout the state as to how your cost-of-living adjustments are calculated, whether your salaries keep pace with inflation, and as to how you feel about resident responsibility for keeping health care costs down—particularly when the bite might hit your own pocketbook.

**AMA Newsletter:* 10, No. 27, July 31, 1978, p. 3.

Blue Cross®
Blue Shield®

# REPORT
## FOR *Illinois Physicians*

## HIGHER UTILIZATION OF COST-EFFECTIVE PROGRAMS URGED

The Illinois Blue Cross and Blue Shield Plan is urging physicians, hospital administrators and all providers of patient care to utilize more extensively the Plan's cost-effective programs in Pre-Admission Testing for Surgery Patients (PAT), Ambulatory Surgery, Coordinated Home Care and care in Extended Care Facilities.

In a recent announcement to hospital administrators and chiefs of staff, the cost-saving advantages of the Pre-Admission Testing program and Ambulatory Surgery were cited, with the request that such programs be further implemented and utilized to effectively reduce patient-care expenses.

The announcement also stated that the Plan would be monitoring utilization to identify services which could have been carried out in ambulatory surgical settings or on a Pre-Admission Testing basis.

A list of surgical procedures which normally can be performed on an ambulatory basis, and a similar listing of elective surgical procedures for which Pre-Admission Testing would be appropriate were supplied with the announcement.

*The Pre-Admission Testing Program for Surgical Patients:*

Blue Cross and Blue Shield has applied new criteria to the Pre-Admission Testing Program for surgical patients to expand its utilization. For example:

—Tests ordered by the physician prior to surgery may be performed in a non-hospital setting, i.e. in an approved medical laboratory, medical clinic, or free-standing ambulatory surgical facility (in addition to a participating hospital's outpatient department).

—Payment for eligible Pre-Admission tests and examinations is made directly to the Plan-approved provider of services by Blue Cross and Blue Shield. Charges for repeat tests and examinations are not eligible for payment.

—The PAT program is available to patients who are scheduled for ambulatory surgery.

Currently, 117 hospitals and medical facilities participate in the PAT program. A list of the facilities is available in a brochure on the program from Blue Cross and Blue Shield.

Provisions of the program remain otherwise unchanged:

After a surgical diagnosis has been established and surgery is scheduled at the hospital or ambulatory surgical facility, the tests and examinations normally required before elective (non-emergency) surgery are ordered by the attending physician—usually 3-4 days before surgery is to be performed. The doctor then receives the results of ths tests.

The results become a part of the patient's record, whether he or she is admitted as an inpatient of the hospital for surgery or if the patient is discharged following an ambulatory surgical procedure.

All charges for PAT services are paid in accordance with the benefits described in the member's Blue Cross and Blue Shield certificate, even if the surgeon decides to postpone or cancel surgery. However, benefits are not paid if the patient decides against surgery.

The PAT program does not cover members enrolled in the supplementary Blue Cross 65 and Blue Shield 65 program. Medicare-eligible patients may receive outpatient tests covered by Part B Medicare with payment up to 80% of the reasonable charges. The patient pays the 20% co-insurance and the $60 annual deductible (or any portion of an unpaid deductible).

*The Ambulatory Surgery Program:*

Blue Cross and Blue Shield subscribers with certificates that include outpatient services, are eligible for ambulatory surgery benefits in approved facilties, provided the surgeon considers the procedure appropriate treatment for the patient's condition. (The Plan's Medical Department has compiled a list of surgical procedures which often can be performed on an ambulatory basis, which is available to physicians).

This cost-effective program has been growing steadily since its inception and development in hospitals. Blue Cross and Blue Shield has been a proponent of the programs and has approved ambulatory surgery programs at 65 Illinois hospitals and five free-standing ambulatory surgery faciilties.

Provisions of this program are:

The patient is admitted to a Plan-approved participating hospital's ambulatory surgical department or a licensed and approved free-standing ambulatory surgical facility on the day that surgery is to be performed, and prepared for the operation;

After surgery, the doctor, nurses and anesthesiologist monitor the patient's condition in the recovery area to make certain that recovery is satisfactory and the patient can be sent home safely.

When it is determined that the patient may leave the hospital, and arrangements have been made for transportation, the patient is discharged with instructions for care that may be necessary at home for complete recuperation.

In rare instances, when the patient must remain in the hospital, he is transferred to a hospital bed for inpatient care.

(Leaflets are available on the above programs from the Public Relations Department of Blue Cross and Blue Shield, 233 N. Michigan Ave., Chicago, Illinois 60601).

# Medical Necessity Program for Medicare

In the December, 1977 issue of the *Illinois Medical Journal*, a list of procedures was given for which routine payment would no longer be made. The medical consultants in the Public Health Service were asked to review the procedures and their report was recently received.

Public Health Service concluded that, in general, these procedures are either of dubious effectiveness or outmoded, and have been replaced by better modalities of diagnosis or treatment. This conclusion was reached after consultation with authoritative medical sources within and outside the Department of Health, Education, and Welfare. PHS has recommended that Medicare not cover some of these procedures, that others be paid for only if the physician who performs the procedure satisfactorily justifies the medical need for it, and in some cases, only if the physician who performs the procedure justifies the medical need for it when performed for a specific condition.

Based upon the recommendations of PHS, the procedures listed in Categories A and B are covered as reasonable and necessary procedures when the medical need is satisfactorily justified. The special coverage requirements apply to Category B procedures only if the procedure is performed for the indicated condition. When Category B procedures are performed for conditions other than those indicated in the list, the procedure may be covered according to the normal reasonable and necessary rules and the special justification required by this instruction is not needed in every case. The procedures in Category C are not covered.

A. *Procedures covered only upon satisfactorily justification of medical necessity.* (Category A)

1. Angiocardiography plain films or single views (single plane or multiplane)
2. Angiocardiography utilizing $CO_2$ method
3. Angiography—extremity, unilateral, single view (unless emergency)
4. Basal metabolic rate (BMR)
5. Circumcision, female
6. Coronary angiography, unilateral selective injection, single view (unless emergency)
7. Hypogastric or presacral neurectomy (independent procedure)
8. Hysterotomy, nonobstetrical, vaginal
9. Kidney decapsulation
10. Nephropexy (independent procedure)
11. Omentopexy for establishing collateral circulation in portal obstruction
12. Perirenal insufflation
13. Phonocardiogram
14. Radical hemorrhoidectomy, Whitehead type
15. Supracervical hysterectomy
16. Uterine suspension with or without presacral sympathectomy

B. *Procedures covered only upon satisfactory justification of medical necessity for a specific condition.* (Category B)

1. Fascia lata by incision and area exposure, as treatment for lower back pain
2. Fascia lata by stripper, as treatment for lower back pain
3. Ligation of femoral vein, as treatment for post-phlebitic syndrome
4. Sympathectomy, thoracolumbar or lumbar, as treatment for hypertension

C. *Procedures excluded from coverage.* (Category C)

1. Ballistocardiogram
2. Icterus index
3. Ligation of internal mammary arteries
4. Protein-bound iodine (PBI)

## Changes in Participation and Certification of Laboratory Procedures

Notices were received from the Medicare Bureau of the following changes in participation and certification of procedures of laboratories in the Medicare program.

Fox Valley Medical Laboratory, 866 Summit Street, Elgin, Illinois 60120 (Provider Number 14-8130) is no longer approved to perform Procedure 520-Rh Titers, effective August 1, 1978. The laboratory is approved to perform Procedures 220-Serology; 310-Chemistry Routine; 320-Clinical Microscopy; 510-Blood Group and Rh; 600-Pathology and 710-EKG Services.

**Changed Ownership:**

Harvey Medical Laboratory, 15320 South Center Ave., Harvey, Illinois 60426 changed ownership, effective June 12, 1978. The laboratory continues to meet the requirements for coverage of its services under the Medicare program.

**Closing:**

Community Medical Laboratory, 1413 South Ninth Ave., Maywood, Illinois 60153 (Provider Number 14-8175) closed, effective June 30, 1978. No payment can be made under the health insurance program for services rendered on or after the effective closing date.

*(This report is a service to the physicians of Illinois)*



# the view box

Leon Love, M.D./Chairman/Department of Radiology
Loyola University Stritch School of Medicine

*This 29-year-old patient received a renal transplant for chronic renal failure as a result of glomerulonephritis. One week after surgery the patient developed a tender mass over the site of the donor kidney. A CAT scan was done.*

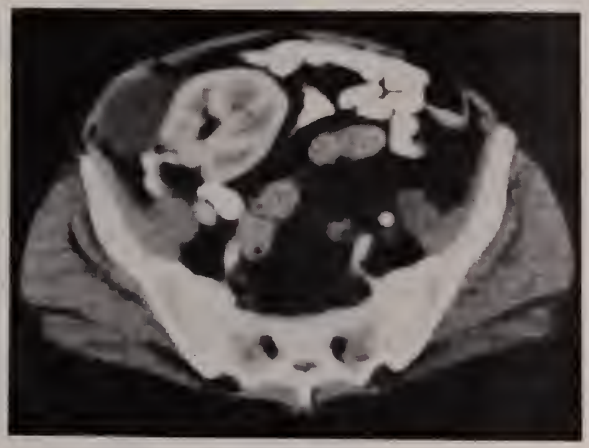


**Figure 1**

## What is your diagnosis?

*(Continued on page 145)*

# AFRICAN ADVENTURE

Is Morocco and Kenya. Wander the narrow streets of the Casbahs in ancient Rabat and mysterious Casablanca. Shop in colorful souks. Visit Djemaa El Fna Square in Marrakech, teeming with storytellers, snake charmers and soothsayers. Roam the vast game parks of Kenya by safari rover. Capture elephant, zebra and lion on film. Relax at luxurious lodges or take a trip into Masai and Kikuyu native villages. Lounge on the sands of Mombasa and let the warm Indian Ocean soothe you. Discover enough native artifacts to start your own museum.



Join our two-week Adventure to the land that fascinated Hemingway — before it disappears forever. We depart **Chicago** on **February 27, 1979,** returning on **March 13, 1979.** Leave winter behind . . . escape to Africa.

**$1628.00**
includes chartered round-trip jet flights, deluxe hotel in each city, full American breakfast, and dinner each evening at a selection of the finest restaurants.

**Make Your African Adventure Reservations Today!**

Send to: Illinois State Medical Society
55 East Monroe, Chicago, Illinois 60603

Enclosed is my check for $_____($100 per person), as deposit.

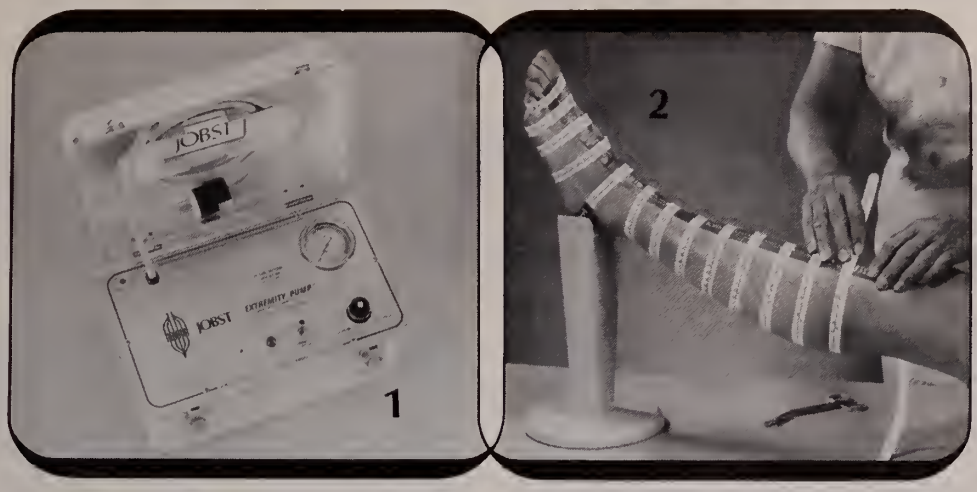
Name _____

Home Address _____

City _____ State _____ Zip _____

Area Code _____ Phone _____

**A Non-Regimented INTRAV Deluxe Adventure**




# Twin Engineering Devices, to Reduce Massive Lymphedema, and Maintain the Reduction.

Massive and obstinate lymphedema of the limbs may be reduced through use of the Jobst Extremity Pumps (Intermittent Compression) (photo 1). Its controlled pneumatic massage gently removes edema fluid from congested areas.

Jobst Extremity Pumps are available in hospital, clinical, and home models (shown), the latter being available on rental. All units have controls to vary both pressure and time cycles.

When the desired reduction is attained, it can be maintained with a *Jobst Venous Pressure Gradient®* Support. These supports are custom-made to your prescription and the patient's individual measurements (photo 2). You may prescribe exact counterpressures. "In-Patient" orders will be given special attention.

**Contact your local Jobst Service Center for complete details.**

## JOBST CHICAGO SERVICE CENTER

**Chicago, Illinois 60602**
Suite 2101, Pittsfield Bldg.
55 E. Washington Street
312/346-0446

# PUT YOUR **TOWN** ON THE MAP

## HELP COMPLETE THE MEDICAL CARE PICTURE

**December 10, 1978**
**Sheraton Oakbrook**
**Oakbrook, Illinois**




**Doctor's Job Fair**
Illinois State Medical Society
55 E. Monroe—#3510
Chicago, IL 60603

Please send more information regarding the Doctors Job Fair, December 10, 1978.

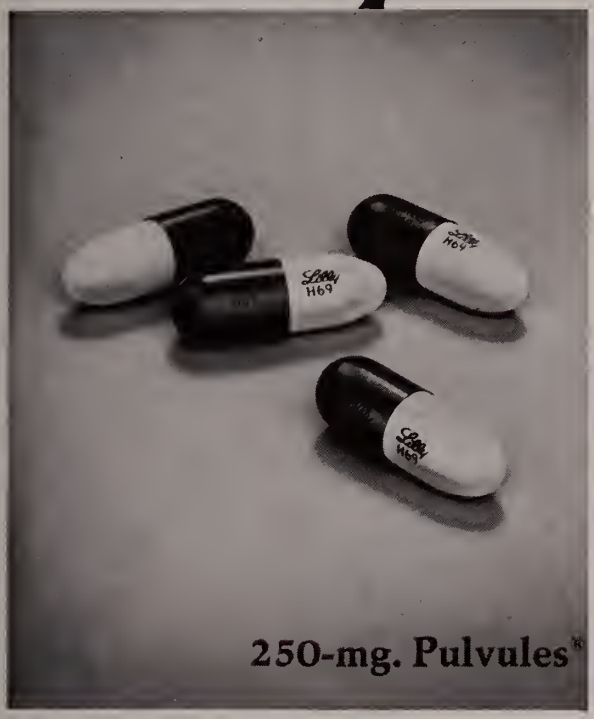
**(Please Print)**

**NAME** _____

**ADDRESS** _____

**CITY, STATE, ZIP** _____

# easy to take







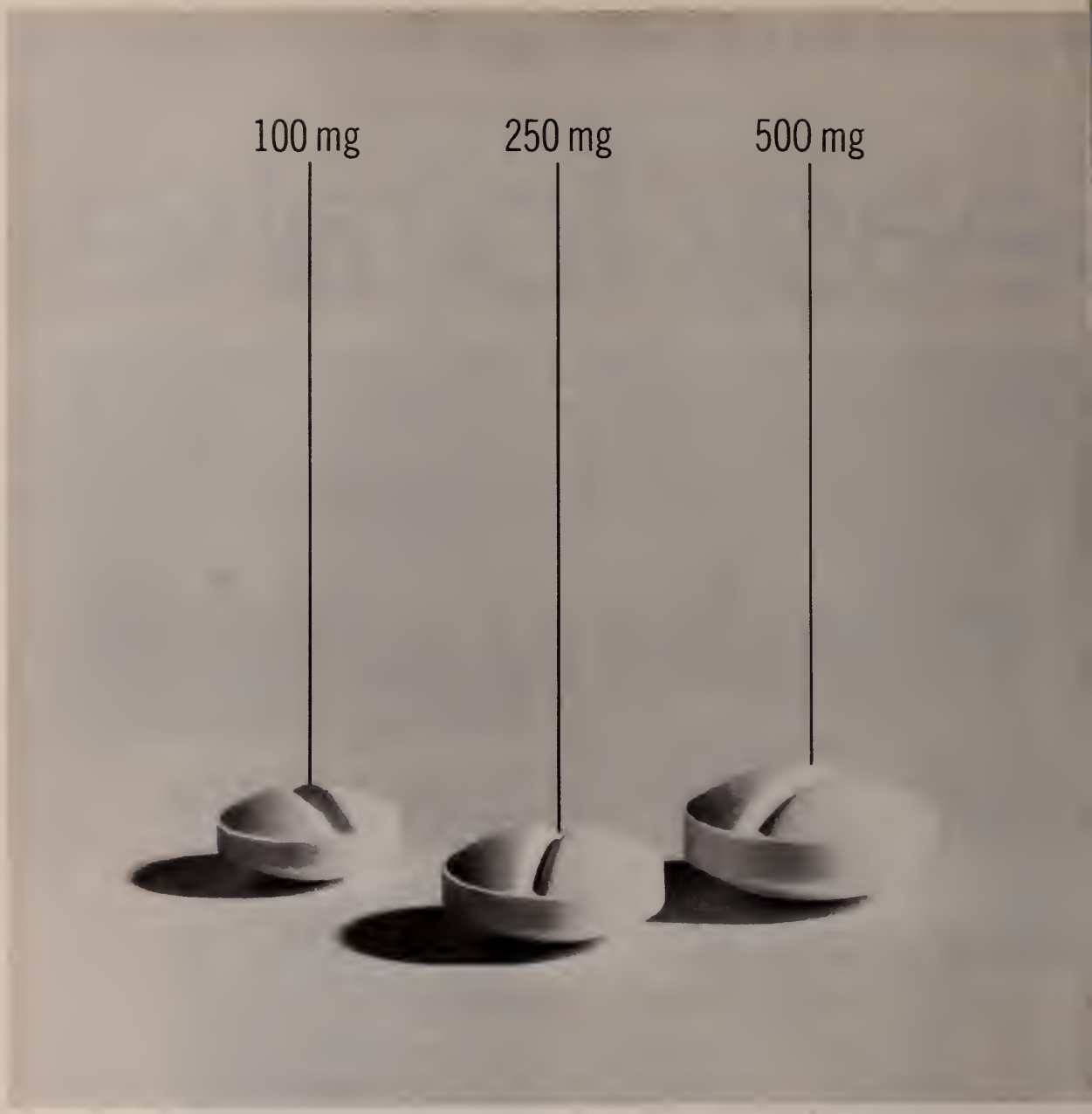



# Keflex®
## cephalexin

Lilly

*Additional information available to the profession on request.*
Eli Lilly and Company
Indianapolis, Indiana 46206

500738




# Tolinase®
## tolazamide, Upjohn

Please contact your Upjohn representative for additional product information.

Upjohn

J-5695-6

©1977 THE UPJOHN COMPANY

IMJ
Illinois Medical Journal
Vol. 154, No. 3, September, 1978

# Delayed Hemolytic Transfusion Reaction

By Bak M. Lee, M.D./Normal

*A case of delayed hemolytic transfusion reaction is reported. Previously reported cases are reviewed. Clinical findings, laboratory findings and cause of delayed hemolytic transfusion reaction, as well as related problems, are discussed.*

Delayed hemolytic transfusion reaction can be defined as a hemolytic transfusion reaction due to isoantibody against donor erythrocytes in which recipient was previously sensitized, but standard compatibility test at the present time failed to detect the antibody, possibly because antibody titer was extremely low or completely absent. However, a transfusion stimulates antibody formation, possibly an amnestic reaction resulting in rapid increased antibody level, within a few days after transfusion (usually three to seven days). In most cases, delayed hemolytic reaction shows very mild symptoms and signs, but there is a reported case with acute renal failure. The cases are usually seen in persons with a history of pregnancy or previous transfusion. Common isoantibody detected at the time of delayed hemolytic transfusion reaction is Kidd, especially anti Jka and Rh system, most often anti E and anti C.



BAK M. LEE, M.D., is o pothologist affiliated with Brokow Hospital in Narmol, Illinais. Doctar Lee, a fellow of the College of American Pathologists and American Society of Clinical Pathologists, is certified by the American Board of Pathology in anatomical and clinical pathalagy and the subspecialty baard in blood banking.

## Report of a Case

A 74-year-old male was admitted to the hospital with complaints of acute abdominal pain and rectal bleeding. He had several previous admissions to the hospital for peptic ulcer of duodenum, cholelithiasis. A peptic ulcer with bleeding had been diagnosed in 1961, at which time he had received two units of blood because of excessive bleeding. At the time of admission, he apparently was relatively stable. Blood pressure was 124/76, pulse was 86/min. and regular, hemoglobin was 12 gram%, and hematocrit was 34%. His blood type was found to be type O, Rh+. Shortly thereafter, he started active rectal bleeding and was given three units of type O, Rh+ blood. There was no evidence of irregular antibody detection and these three units of blood were compatible. The urinalysis was nonspecific. Blood chemistry revealed slightly increased glucose, BUN, creatinine and uric acid. Total protein was slightly lower than normal with

slightly low albumin. Bilirubin was 1 mg% with direct bilirubin of 0.2 mg%. The patient had continuous rectal bleeding. On the second and third days of his hospital admission, five additional type O, Rh+ blood units were given, at which time there also was no detectable irregular antibody in his serum. These five units of blood were compatible. X-ray study confirmed that he had a duodenal ulcer and brought a clinical diagnosis of peptic ulcer in duodenum with active bleeding. His hemoglobin was 12.6 grams and his hematocrit was 36.1%. On the fourth and fifth days of hospitalization, his rectal bleeding stopped and he was in relatively stable condition. However, his hemoglobin was shown to drop slowly to 10.4 grams and his hematocrit slowly dropped to 29.6%. On the sixth day of hospitalization, his hemoglobin dropped to 9.9 grams and his hematocrit dropped to 28.1%. Two additional units of type O, Rh+ blood were given. A few hours after completion of the second unit of the blood transfusion, the patient developed left chest pain, radiating to the left arm and showed signs of fever. His body temperature had been about 37.3C. However, it became 38.9C. EKG revealed sinus tachycardia but there was no detectable evidence of acute myocardial infarct. Chemistry profile revealed relatively non-specific change except for elevated CPK enzyme. CPK isoenzyme, however, revealed no evidence of elevated myocardial CPK enzyme. The patient also showed signs of jaundice. Blood bilirubin revealed 3.1 mg%, while urinalysis revealed no recognizable evidence of hemoglobin in the urine. His urine output was adequate and there was no evidence of congestive heart failure or oligouria. Immunohematological study revealed that the patient showed positive direct Coombs test and c antibody in his serum. Repeat test on previously drawn patient's serum showed no detectable isoantibody. The previously tranfused ten units of blood revealed c positive except for one unit. Because of adequate urine output and no significant signs of severe hemolysis, nonspecific treatment was initiated. He slowly recovered from the jaundice. On his ninth hospital day, two additional units of type O, Rh+, c negative blood were given because of rectal bleeding and anemia. Also, two additional units of type O, Rh+, c negative blood were given on the tenth day of hospitalization because of rectal bleeding and anemia. The patient responded adequately to the transfusions. His hemoglobin and hematocrit rose to 12.4 grams and 35.8%. His rectal bleeding appeared to have stopped and his condition became stable until the time of his discharge, a month after his admission.

**Discussion**

It is rare to experience a delayed hemolytic transfusion reaction. However, it is very important to recognize it. Since it is impossible to predict a possible delayed hemolytic transfusion reaction prior to transfusion by the present immunohematological techniques, careful clinical observation after tranfusion is necessary. The delayed hemolytic transfusion reaction was explained[1,2] as: (1) the antibody produced by previous transfusion or pregnancy may be absent due to complete disappearance from the circulation at the time of crossmatch, (2) the antibody may be present in such a low titer as not to be detectable, (3) the transfusion may provoke a rapid amnestic reaction producing antibody in about one week after transfusion, (4) rapid increase in antibody concentration causes rapid destruction of the transfused erythrocytes.

In reviewing the literature, experience was reported in transfusion of compatible blood resulting in hemolysis of donor blood without demonstrable antibody as early as 1943.[3] Fudenberg and Allen[4] reported two well-documented cases in which hemolytic blood transfusion reaction due to specific isoantibody, anti E and anti K, had been observed. These patients had previous transfusions. No incompatibility could be demonstrated by available pretransfusion tests. Since then, there have been several additional articles published.[1,5,6] Recently, Pineda, Taswell and Brzica published their collections of twenty-three cases.[7] Delayed hemolytic transfusion reaction is rare and shows relatively mild symptoms in most cases. The most common symptoms[8] are fever, chills, nausea and vomiting, flank pain, shortness of breath, mild anemia and mild jaundice. Chest pain might occur, simulating acute myocardial infarct, as seen in the present case. Laboratory findings are consistent with intravascular hemolysis, such as mild anemia, increased bilirubin with increased indirect bilirubin, markedly elevated LDH, presence of free hemoglobin in plasma and hemoglobin in urine, depending upon severity of hemolytic reaction. In a case of renal failure, there will be symptoms, signs and laboratory findings consistent with renal failure, such as increased BUN and creatinine.[9] At the time of hemolytic transfusion re-

action, immunohematological work-up reveals (a) isoantibody in the post-transfusion recipient serum which was not detected in pretransfusion serum, (b) positive direct Coombs test which was negative in pretransfusion serum, and (c) specific isoantigen presence in donor cells against specific antibody detected in post-transfusion recipient serum. There are cases reporting that specific antibody was not identified, although direct antiglobulin test was positive[10] or antibody was detected, but direct antiglobulin test was negative.[9] In these cases it could be explained that newly developed antibody was entirely attached to the transfused donor's erythrocytes or most of donor's erythrocytes attached by recipient's antibody were destroyed. In a case of direct antiglobulin test positive without any detectable antibody present in the recipient's serum, eluate method of recipient's blood sample will demonstrate a specific isoantibody against donor cells. In case of hemolytic reaction due to $A_1$[10] antibody cannot be detected by using panel cells, although serum contains antibody, because panel cells are type O. Commonly found isoantibodies responsible for delayed hemolytic reaction are $Jk^a$, $Jk^b$, E, c, K, S, s, $Le^a$, $Le^b$, and $Fy^a$.[2] This observation is found to be very similar in a recent study.[7] Rarely, another isoantibody was found to be responsible for delayed hemolytic transfusion reaction, including anti $A_1$.[10] Since the symptoms of hemolytic transfusion reactions are mild and do not require any specific treatment, the previously recorded cases show uneventful recovery within several days with no specific treatment except for a case reported with renal failure. In order to make a diagnosis of delayed hemolytic reaction including all kinds of transfusion reaction follow-ups, a hospital laboratory needs[11] (1) patient's pretransfusion blood, (2) patient's post-transfusion blood, (3) donor's blood sample, blood bag and/or segment, and (4) patient's post-transfusion urine. The confirmation of delayed hemolytic transfusion reaction was usually made a few days after transfusion when the patient had already developed a hemolytic reaction. It is recommended to repeat hemoglobin a few days after transfusion. If the patient shows a decreased hemoglobin without any clear explanation, the possibility of delayed hemolytic transfusion reaction should be considered, especially in patients who have a history of previous transfusions, pregnancy or irregular antibody detection. If the patient had been noted to have previous antibody present, careful follow-up after transfusion is necessary. ◄

**References**


1. Roy, R. B., and Lotto, W. N.: "Delayed Hemolytic Reaction Caused by Anti c Not Detectable Before Transfusion," *Transfusion*, 2:342-343, 1962.
2. Howard, P. L.: "Delayed Hemolytic Transfusion Reaction," *Ann. Clin. Lab. Sci.*, 3:13-16, 1973.
3. Loutit, F., Mollison, P. L. and Young, I. M.: "Citrate Acid-sodium Citrate Glucose Mixture for Blood Storage," *Quart. J. Exp. Physiol.*, 32:183-202, 1943.
4. Fudenberg, H., and Allen, F. H., Jr.: "Transfusion Reactions in the Absence of Demonstrable Incompatibility," *N. Eng. J. Med.*, 256:1180-1184, 1957.
5. Walker, P. C., Jennings, E. R. and Monroe, C.: "Hemolytic Transfusion Reaction after the Administration of Apparently Compatible Blood," *Am. J. Clin. Pathol.*, 44:193-197, 1965.
6. Morgan, P., Wheller, C. B., Jr. and Bossom, E. L.: Delayed Transfusion Reaction Attributed to Anti $Jk^b$," *Transfusion*, 7:307-309, 1967.
7. Pineda, A. A., Taswell, H. F. and Brzica, S. M. Jr.: "Delayed Hemolytic Transfusion Reaction, an Immunologic Hazard of Blood Transfusion," *Transfusion*, 18:1-7, 1978.
8. Bear, D. M.: Blood Banking for the Hospital Laboratories, *Am. Soc. of Clin. Path.*, p. 71, 1977.
9. Meltz, D. J., David, D. S., Bertles, J. F. and deAutiis, A. C.: "Delayed Hemolytic Transfusion Reaction with Renal Failure," *Lancet*, 2:1348-1349, 1971.
10. Lundberg, W. B. and McGinniss, M. H.: "Hemolytic Transfusion Reaction due to Anti $A_1$," *Transfusion*, 15:1-9, 1975.
11. Miller, W. V.: Technical Manual, American Association of Blood Banks, seventh edition, p. 250, 1977.



**COOK COUNTY**

**Graduate School of Medicine**

CONTINUING EDUCATION COURSES
STARTING DATES—1978

ESSENTIALS OF ELECTROCARDIOGRAPHY, 5 days, September 18
EKG FOR ANESTHESIOLOGISTS, 5 days, September 18
SPECIALTY REVIEW DERMATOLOGY, 5 days, September 25
SPECIALTY REVIEW OBSTETRICS & GYNECOLOGY, September 25
SEXUAL MEDICINE, 5 days, September 25
NEUROLOGY, PART II, CLINICAL, October 9
QUALITY ASSURANCE EVALUATION, 3 days, October 12
CLINICAL & LABORATORY DIAGNOSIS OF HEMORRHAGIC AND THROMBOTIC DISORDERS, 2 days, October 20
MANAGEMENT OF COMMON FRACTURES, 5 days, October 23
SPECIALTY REVIEW SURGERY, PART I, October 23
RECENT ADVANCES IN PSYCHIATRY, 5 days, October 23
RECERTIFICATION REVIEW IN OB-GYN, 5 days, October 30
RECENT ADVANCES IN NEUROLOGY, 5 days, November 13
ADVANCES IN MEDICINE, 5 days, November 13
MANAGEMENT OF HIGH RISK OBSTETRICAL & NEWBORN PROBLEMS, Nov. 13

*Information concerning numerous other continuation courses available upon request.*

**Address:**
**REGISTRAR, 707 South Wood Street,**
**Chicago, Ill. 60612**

# Non-Cardiac Creatine Phosphokinase Activity Elevation

JOHN A. DAMERGIS, M.D. AND JEROME M. STOKER, M.D./ELMHURST

*In recent years, serum creatine phosphokinase (CPK) activity has been noted to play an important role in diagnosing myocardial injury.[1,2] Since this activity is also noted in skeletal muscle and neurologic disorders,[3,4] isoenzymes have been used to localize the organ system of involvement.[5] The purpose of this paper is to present a case of a young individual with chest pain and high CPK activity, the etiology of which turned out to be musculoskeletal.*

A young, athletic, soccer-playing individual presented with chest pains, non-specific electrocardiograph, and high creatine phosphokinase enzyme values, specifically skeletal muscular fraction, in all likelihood related to athletic trauma.

Patient was a 29-year-old black male engineering student who presented to the emergency room with a seven-day history of progressive chest pain, which was substernal, pleuritic, and radiating to the dorsal spine. Past medical history was noncontributory. The patient did admit to heavy sports activity, specifically soccer playing, during which he had sustained frequent blows to the chest wall. The physical examination was unremarkable and failed to elicit any tenderness to direct sternal palpation. Laboratory studies showed the chest X-ray to be normal, while the electrocardiograph had non-specific ST-segment changes. Admission hemoglobin, hematocrit, white blood count, glucose, blood urea nitrogen, creatinine, calcium, phosphorus, electrolytes, cholesterol, bilirubin, urinalysis and erythrocyte sedimentation rate were all within normal limits. Serial studies of elevated enzymes, specifically skeletal CPK isoenzymes, are shown in Table 1.

The patient was admitted to the coronary care unit for observation. He was asymptomatic after the first hospital day, coincident with being placed on a musculoskeletal relaxant, Valium (diazepam). Serial electrocardiographs remained non-specific, with no evidence of any evolving acute changes. He was discharged on the fifth hospitalization day.

Three weeks after discharge the results of the isoenzyme studies became known. The patient underwent a graded exercise test, during which his heart rate was carried up to 94% of the expected rate. His electrocardiographic response was normal, and there was no evidence of chest pain or arrhythmia. Creatine phosphokinase isoenzymes were obtained before exercise, immediately after exercise and some ten minutes post-exercise. They were all normal, skeletal in origin, and not significantly different from each other.

**Discussion**

Serum creatine phosphokinase has three isoenzymes, BB, MB, and MM, representing brain, cardiac, and skeletal muscle origin respectively. Since CPK activity is elevated in many conditions,[3] the use of isoenzymes can be quite valuable.

The initial CPK value in our patient was quite high, 2621 IU/L. Mean maximum serum CPK values following transmural infarction has been reported to be 605 IU/L.[3] Our patient had no electrocardiographic evidence of transmural infarction. Extensive prolonged exercise, as in military recruits, leading to rhabdomyolysis has been noted to cause very high CPK elevation, the mean value being 76,803 mu./ml.[6] There was no evidence of myoglobinuria in our patient. As was the case in our patient, serum CPK values have been shown not to be significantly affected by exercise testing.[7,9] While neurologic disorders such as meningitis and brain tumor can cause CPK elevation of up to 100 times normal,[3] our patient had no evidence of any neurologic dysfunction.

Our patient may represent a

JOHN A. DAMERGIS, M.D., is an internal and pulmonary medicine specialist affiliated with the Elmhurst Memorial Hospital of DuPage County. Doctor Damergis is a member of both the American College of Chest Physicians and the American Thoracic Society. JEROME M. STOKER, M.D., is a board certified internist affiliated with Memorial Hospital of DuPage County. Doctor Stoker, who serves on the internal medicine staff for the Elmhurst Clinic is a clinical associate professor of medicine at Loyola University Stritch School of Medicine and former vice president of the medical staff at Memorial Hospital.

**Table 1**
**Enzyme Values on Successive Hospital Days**

| | Normal IU/L | First Day Early | First Day Late | Second Day | Third Day | Fifth Day |
|---|---|---|---|---|---|---|
| TOTAL CPK | 0-70 | 2621 | 1594 | 810 | 446 | 169 |
| CPK 1 (BB) | 0-2 | 9 | — | — | — | 3 |
| CPK 2 (MB) | 0-3 | 54 | — | — | — | 6 |
| CPK 3 (MM) | 0-65 | 2549 | — | — | — | 164 |
| SGOT | 7-40 | — | 99 | 72 | 60 | — |
| LDH | 100-225 | — | 342 | 190 | 199 | — |

common problem. An individual with chest pain and non-diagnostic electrocardiographs in association with modest CPK elevation should have a complete history in association with isoenzyme studies. ◄

### References


1. Hess, J. W., MacDonald, R. P., Frederick, R. J., Jones, R. N., Heely, J. and Gross, D.: "Serum Creatine Phosphokinase (CPK) Activity in Disorders Heart and Skeletal Muscle," *Ann. Intern Med.*, 61:1015-1028, 1964.
2. Cohen, L.: "Contributions to Serum Enzymes and Isoenzymes to the Diagnosis of Myocardial Injury," (Part I) *Mod. Concepts Cardiovasc. Dis.*, 36:43-47, 1967.
3. Nevins, M. A., Saran, M., Blight, M., and Lyon, L. J.: "Pitfalls in Interpreting Serum Creatine Phosphokinase Activity," *JAMA*, 224: 1382-1387, 1973.
4. Eschar, J., Zimmerman, H. J.: "Creatine Phosphokinase in Disease," *Am. J. Med. Sci.*, 253:272-282, 1967.
5. Editorial: "Isoenzymes of Creatine Phosphokinase and Diagnosis of Myocardial Infarction, *Ann. Intern Med.*, 79:741-743, 1973.
6. Olerud, J. E., Homer, L. D., and Carroll, H. W.: "Incidence of Acute Exertional Rhabdomyolysis, Serum Myoglobin and Enzyme Levels as Indicators of Muscle Injury," *Arch. Intern Med.*, 136: 692-697, 1976.
7. Forssell, G., Nordlander, R., Nyquist, O., Olinius, E., and Styrelius, I.: "Creatine Phosphokinase After Submaximal Physical Exercise in Untrained Individuals," *Acta Med. Scan.*, 197:503-505, 1975.
8. Chahine, R. A., Kazantzis, A., Luchi, R. J., Raizner, A. E., and Cyorkey, F.: "Effect of Routine Treadmill Testing on the Serum Enzymes," *Cardiology*, 61:162-169, 1976.
9. Galtean, M. M., Siest, G. and Poortmans, J.: "Continuous *in vivo* Measurement of Creatine Kinase Variations in Man During an Exercise," *Clin. Chim. Acta.*, 66:89-95, 1976.



# Director of Medical Education

The Ravenswood Hospital Medical Center, located at 4550 N. Winchester Avenue, Chicago, Illinois, a teaching/community 450 bed hospital, is seeking a geographic full time Director of Medical Education.
The Hospital is affiliated with the Abraham Lincoln School of Medicine of the University of Illinois.
The individual being sought for this position must be board certified or board eligible, with demonstrated competence in his/her specialty; shall have demonstrated professional and administrative abilities, and shall possess a knowledge of current educational principles. He/she will be administratively responsible for the Department of Medical Education and for the coordination and integration of all medical education programs at the Medical Center. The Medical Center offers a competitive salary and benefit program. Qualified applicants please submit resume in confidence, to:

**Chairman, Search Committee for DME**
**c/o The Medical Staff Office**
**RAVENSWOOD HOSPITAL MEDICAL CENTER**
**4550 N. Winchester**
**Chicago, Ill. 60640**
**(312) 878-4300, ext. 1550**
Ravenswood Hospital is an Equal Opportunity Employer

# Epilepsy Services Provided By The Comprehensive Program For Children With Epilepsy

By B. Hermann, Ph.D., E. Page-El, M.D., E. Zurbrugg, M.D., S. Chhabria, M.D., and R. Black, D.S.W./Chicago

*The Comprehensive Program for Children with Epilepsy (CPCE) received endorsement from the ISMS Board of Trustees at its most recent meeting. The service is designed for physicians treating childhood epilepsy who seek experienced consultation. Pediatric neurologists are available to provide this through the CPCE toll-free telephone number. Illinois physicians are encouraged to utilize the CPCE.*

Interest in epilepsy and its psychosocial ramifications has grown rapidly in the last decade. The report by the Commission for the Control of Epilepsy and its Consequences (1977) documents the multifaceted aspects of this ancient disorder, and clarifies numerous existing gaps between needed and available comprehensive services for this population.

The Comprehensive Program for Children with Epilepsy (CPCE) is located at the University of Illinois Medical Center and has been established as a multidisciplinary project committed to the comprehensive care of the child and adolescent with epilepsy. The core CPCE staff consists of professionals from a variety of disciplines: pediatric neurology, neuropsychology, social work, pediatric dentistry, nursing, and occupational therapy. Children seen at CPCE are thus evaluated from a variety of viewpoints. Treatment and follow up also reflect this multidisciplinary approach.

The goals of CPCE are fourfold: (1) comprehensive multidisciplinary care of the child with epilepsy, (2) educational and psychosocial family services, (3) basic medical training and education of students from a variety of disciplines with respect to the care, management, and needs of the child with epilepsy, and (4) community education and services for physicians, laypeople, and ancillary professionals.

BRUCE HERMANN, Ph.D., is an assistant professor of psychology and neurology at the University of Illinois Medical Center.
RITA BLACK, D.S.W., is an assistant professor of medical social work affiliated with the University of Illinois Medical Center department of neurology.
SHAKUNTALA CHHABRIA, M.D., is an assistant professor of pediatrics and neurology at the University of Illinois Medical Center.
E. PAGE-EL, M.D., is an assistant professor of pediatrics and neurology affiliated with the University of Illinois and Rush Pres.-St. Luke's Medical Center.
ERIC ZURBRUGG, M.D., is an assistant professor of pediatrics and neurology affiliated with the University of Illinois Medical Center.

### Telephone Consultation Service

With respect to the latter goal, CPCE has initiated a project which may be of interest to Illinois physicians. Beginning September 1, 1978, CPCE instituted a "Statewide Telephone Con-

**Table 1**

***Intake Information for Consultation Service***

**In order to facilitate efficient utilization of the service, physicians calling for consultation are asked to prepare the following data for CPCE records:**
**Complete patient identification**
**Seizure type and frequency**
**Current medications**
**Date and results of last blood level and EEG**
**Related test results (e.g., CAT, X-ray)**
**Additional disabilities or complicating factors**
**Specific questions**

sultation Service for Physicians." A toll free number is available for Illinois physicians who desire consultation from a pediatric neurologist. The consultation may concern diagnosis, management, and/or treatment problems arising in the course of attending to a child or adolescent with epilepsy.

The procedure is as follows: the physician simply calls the toll free number, 800-312-972-3380 and gives preliminary information to the nurse. Pertinent data would include patient identification, laboratory tests, current medications and known complications. The nurse routes the information sheet to one of the CPCE's pediatric neurologists, who will return the call to consult with the physician.

This is a completely novel service and appears to be the first of its kind in the country. We envision this to be a useful service to physicians in Illinois whose expertise is in areas other than epileptology, yet who are called to treat seizure patients in the course of their practice. Provisions have also been made to handle non-neurological complications. Pediatric dentistry, psychology and social work professionals have agreed to lend their expertise when requested by the physician (for instance: in cases of dental complications, placement, behavioral problems, school difficulties, etc.), although the primary thrust is medical.

This service is not intended for use by the person with epilepsy or his/her family. The Illinois Epilepsy Association (312-323-9880) and its affiliated chapters throughout Illinois are designed to provide this service. Neither is it designed for use by the physician who desires instantaneous consultation; *i.e.,* the patient is in the office and the physician desires immediate information. It is hoped that CPCE's pediatric neurologists will be able to return calls within 24 hours.

## Additional CPCE Projects

### *Satellite Clinics*

Plans are currently under way to open "satellite CPCE clinics." The staff of CPCE will hold monthly clinics in outlying areas where specialized epilepsy services are minimal. The satellite clinics are designed to bring comprehensive services to the epilepsy patient and his family, as well as provide a useful resource to local physicians. The first CPCE satellite clinic opened last month in Kankakee.

### *Education Programs*

Educational epilepsy workshops have been designed for four audiences: physicians, nurses, mental health professionals and lay persons. Although the format, goals and accreditations vary, the overall aim is to better familiarize the audience with multidisciplinary aspects of epilepsy. Additionally, a "Counselor's Guide for Epilepsy in Illinois" is being created by CPCE for possible publication and distribution by the State of Illinois. This manual will be aimed at those non-medical people who are likely to work with the seizure patient in a counseling situation (*e.g.,* vocational rehab counselors, mental health professionals) and is specifically designed to acquaint those professionals with the multidisciplinary aspects of seizure disorders.

### *Minimal Care Unit*

In FY 1979 we plan to open a special "Minimal Care Unit for Epilepsy" for children with poorly controlled epilepsy. The clinic could provide monitor and medication control without the expense and inconvenience of regular hospitalization. The unit would accommodate parents and the patients who live a long distance from the medical center and require extended outpatient testing.

## Summary

A variety of services related to epilepsy will become available to consumers, physicians and other professionals throughout Illinois as CPCE progresses. The telephone consultation service was initiated on September 1, 1978. Epilepsy workshops for physicians are planned in conjunction with the Illinois State Medical Society. ◄

### References

The Commission for the Control of Epilepsy and its Consequences, Plan for Nationwide Action on Epilepsy, 1977, Dept. HEW Publication No. (NIH) 78-276.

## *Obituaries*

°Bernier, Jean Richard, Chicago, died August 1, 1978, at the age of 55. Doctor Bernier was a 1947 graduate of the Loyola University Stritch School of Medicine.

°Black, Arnold, River Forest, died August 10, 1978, at the age of 61. Doctor Black was a 1941 graduate of the UI Medical Center.

Donaldson, Alan W., LaGrange, died in August, 1978.

Forkosh, Max P., Chicago, died in August, 1978.

°Hur, Daniel Kyoo, Manteno, died July 16, 1978, at the age of 76. Doctor Hur, with his wife, Dr. Naomi Kim, founded Hillman Memorial Hospital in Manteno, Ill., in 1947.

°Kopstein, Benjamin B., Chicago, died August 22, 1978, at the age of 77. Doctor Kopstein was a 1930 graduate of the Loyola University Stritch School of Medicine.

Leffingwell, Harold R., Lake Forest, died August 12, 1978, at the age of 79.

°Loewenherz, Richard S., Crystal Lake, died August 8, 1978. Doctor Loewenherz was born in Graz, Austria, in 1906 where he earned his medical degree.

Nystul, Oliver A., Lauderdale By the Sea, Florida, died July 27, 1978, at the age of 80. Doctor Nystul practiced medicine in Chicago for 42 years.

°°Parr, Samuel E., Ottawa, died August 8, 1978, at the age of 95. Doctor Parr was a 1909 graduate of Hahnemann Medical College in Chicago.

Salk, Charles M., died in August, 1978.

°°Smith, Clifford E., DeKalb, died July 30, 1978, at the age of 94.

°Sokolowski, Joseph F., Chicago, died July 19, 1978. Doctor Sokolowski was a 1929 graduate of the Loyola Stritch School of Medicine.

°Stone, Robert G., Elgin, died August 6, 1978, at the age of 57.

°Zmugg, Andrew James, Aurora, died July 16, 1978, in Austria.

*°Indicates ISMS member.*
*°°Indicates member of the ISMS Fifty Year Club.*

# President's Tour Dates Announced

The final dates for Doctor David Fox' President's Tour have been announced. Doctor Fox will visit the Peoria County Medical Society on Sept. 19, Will/Grundy Sept. 22, and Jackson County Sept. 26.

In October, six presentations are scheduled. Morgan Scott County Medical Society will meet on the third, Rock Island the 10th, Kane County the 11th, Champaign County the 12th and Macon County the 24th.

Doctor Fox will begin his November visits with SIMA on the ninth, followed by Madison County Medical Society on the 14th, DuPage County the 15th and Sangamon County on the 18th.

In January, he will meet with St. Clair County, Winnebago and Will/Grundy Counties on the fourth, ninth and 10th, respectively.

LaSalle County Medical Society will host Doctor Fox on February eighth, followed by McLean on the 13th and Adams on the 19th.

Doctor Fox will conclude his tour on March 13th, when he will meet with the Lake County Medical Society.

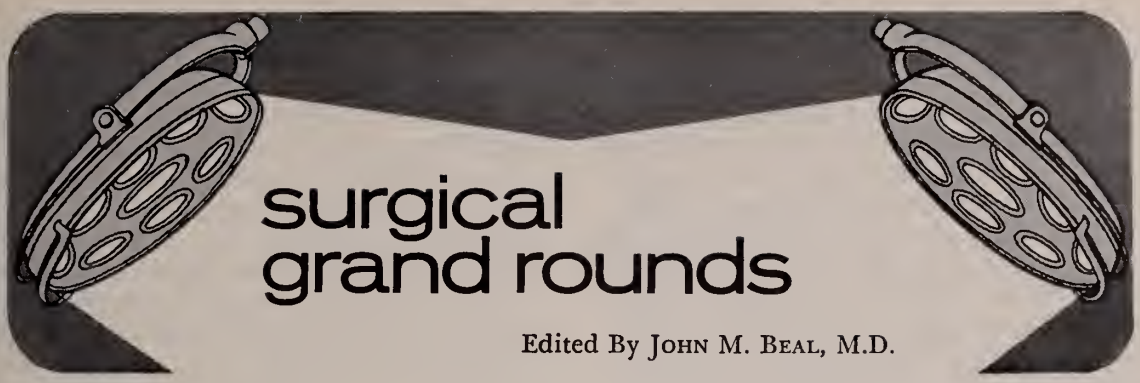
For further information, contact your local county medical society office.

# ISMS Travel Programs

The following ISMS-sponsored travel programs have been scheduled for the remainder of 1978 and 1979:

Dec. 19-27—West Indies Christmas Cruise (Leeward/Windward Islands)
Feb. 27-Mar. 13—Africa (Morocco/Kenya)
June 24-July 5—Rhine Cruise (Munich, Rhine River, Brussels)
July 30-Aug. 12—European Adventure (Paris, Interlacken, Florence)
Sept. 2-15—Danube Cruise (Vienna to Istanbul)

Reservations cannot be accepted without the official form printed in promotional brochures, which will be mailed to all ISMS members and auxiliary at least five months in advance. Individuals outside a member's immediate family will be placed on standby status until all ISMS members have had reasonable time to make reservations. Promotional expenses connected with these programs are paid by tour operators. For further information, please contact ISMS headquarters.




Edited By John M. Beal, M.D.

*Surgical Grand Rounds are held weekly on Tuesday at 5:00 p.m. in the Offield Auditorium of the Passavant Pavilion of Northwestern Memorial Hospital. Patient presentations from Northwestern Memorial Hospital and the Veterans Administration Lakeside Hospital form the basis of the discussions. This case report was part of the Surgical Grand Rounds of January 3, 1978.*

## Case Report

# Cryptorchidism

**Dr. Eli Michaels:** The patient for presentation today is an 11-year-old white boy with bilateral undescended testes who had been treated for at least one year by his pediatrician. The patient was free of urologic symptoms and had not had previous surgery. He had not received hormonal therapy in the past. He was an adopted child and family history was not available. Physical examination revealed a prepubertal male who appeared to be his stated age. The penis was circumcised and normal in appearance, but his scrotum was bilaterally undeveloped. Two small testes were palpated, one in each inguinal canal. Laboratory studies included a normal SMA 6 and urinalysis. The patient was taken to the operating room and bilateral inguinal exploration was performed. Small testes were found, one on either side, and orchiopexy was easily accomplished using chronic catgut suture. The patient made an uneventful recovery.

### Review of Literature

The incidence of cryptorchidism has been estimated to be one percent of all male children at the age of one year. Before one year of age, the testes may yet descend but they rarely do so after that age. One-tenth of this one percent have bilateral cryptorchidism. In a much smaller fraction, testes are entirely absent. It is postulated that in the absence of congenital chromosomal abnormality, failure to find the testes on exploration is due to torsion of the testes in utero while still in the abdominal cavity. A cryptorchid testes may be palpable in the normal path of descent, usually at the external ring or, as in the case of this patient, in the inguinal canal. It may be palpable in a nectopic position in the perineum, thigh or at the base of the penis. When confronted with a patient who has a nonpalpable or undescended testis, the surgeon must bring the testis into the scrotum for two basic reasons. The first and primary goal is to preserve fertility of the unde-scended testis. It has been shown that spermatocyte maturation begins well before puberty. Recent electron microscopic studies of spermatocyte and sertoli cells in patients with cryptorchid testes demonstrated that these cells have been damaged at the age of 18 months. This is much earlier than had been previously described. Such testes have also been found deficient in DNA synthesis. While all bilateral cryptorchid males of child bearing age are sterile, their counterparts who have had

successful surgery or hormonal therapy have a fertility rate of approximately 50%. Further research has found that a surgically descended testis has an improved histologic appearance when a second biopsy is done one year after the original operation. The normally descended contralateral testis is used as a histologic control.

The secondary goal or therapy for cryptochidism is preventive surveillance of the nondescended testis. There is an increased risk of cancer, primarily seminoma, which is estimated to be 12 to 40 times that of normal. This applies whether the testis remains undescended or is brought down. Therefore, the goal of therapy is to allow easier periodic evaluation by palpation of the testis in the scortum. Orchiopexy is indicated in all young men with cryptorchidism, even when there is little hope for fertility, as in today's patient.

### Therapy

Therapy for undescended testes is basically twofold. It is hormonal or surgical, depending on the age of the patient and the unilateral or bilateral nature of the disease. The mechanism for arrested testicular descent is thought to be deficient endogenous gonadotrophin secretion in utero. Initial therapy is directed to providing this hormonal stimulation to the child.

Human chorionic gonadotropin or HCG is given intramuscularly in doses of 100 mg per pound per week for three weeks. The positive response (or descent) of the testicle is expected within a month. When chyptorchidism is bilateral, which is more suggestive of the hormonal deficiency than when it is unilateral, a success rate of 55% has been quoted when therapy is initiated before the age of 5 years. This includes both palpable and nonpalpable groups. The success rate with unilateral cryptorchidism is only 24% for the same age group, indicating that the mechanism for unilateral disease is primary end-organ failure or mechanical factors, rather than inadequate hormone support. In all cases treated after the age of 5, whether unilateral or bilateral, the success rate for hormone therapy drops to 14%.

### Surgical Approach

If hormone therapy fails, the preferred surgical approach depends on whether the testis is palpable or nonpalpable. An inguinal incision is used for the palpable testis. This allows for a more medial passage of the spermatic cord through the fascia at the external ring, which may give added length to the cord structures and the vessels to the testicle. A midline approach is used for the impalpable testis, whether unilateral or bilateral, because the testis may be found anywhere up to the kidney, and, rarely, within the peritoneal cavity itself. With the midline incision, the plan is to reflect the peritoneum medially and to stay outside of the peritoneal cavity unless retroperitoneal exploration reveals no testis. At that time, intraperitoneal exploration must be undertaken.

Hormonal or surgical therapy are not indicated for the child with retractile testis. A recent study in the Journal of Pediatric Surgery demonstrated that adult males with previous retractile testes have the same fertility rate as the general population and that the hormone treated groups and the non-hormone-treated groups have the same fertility. In the case of retractile testes, it is postulated that the intermittent exposure to higher temperature within the body cavity does not have a long term effect on the fertility of the testes involved.

An interesting and fairly unusual variant of cryptorchidism is the child with bilateral impalpable testes. The question then becomes one of simple nondescent of the testes versus complete absence. When such a child is seen as a newborn, the question of ambiguous genitalia must be answered. This is usually done with buccal smear and chromosomal analysis. Electrolytes and urinary steroids are also obtained for possible adrenogenital syndrome in these children. When a male child is seen at one year of age or later with bilateral impalpable testes, the testes must be proven to be present before surgical exploration is indicated. This is done rather simply by checking the serum FSH and LH levels and the serum testosterone level. If the FSH and LH levels are elevated and the serum testosterone is reduced, it is suggested that there is no functioning testicular tissue. To confirm this, the human chorionic gonadotropin (HCG) stimulation test is done. This requires administration of 2,000 international units of HCG intramuscularly on three consecutive days. The patient with functioning testicular tissue will display its three-fold increase in serum testosterone level within three subsequent days. With such a response, the patient may then be given the full course of hormone therapy and surgery is done if the testes do not descend after a full course of therapy. If such a patient does not have a testosterone response with HCG stimula-

tion, the testes are presumed absent and surgery is not indicated. The stimulation test is especially helpful in children with multiple congenital anomalies, such as "prune belly" syndrome and Noonan's syndrome, which is the male equivalent of Turner's syndrome. Both of these have bilateral cryptorchidism as manifestations of their disease.

One other study has been suggested with cryptorchidism. This is a 10% incidence of upper urinary tract anomalies, the most common of which is duplication. For this reason, an intravenous pyelogram is recommended in these children.

**Dr. Vincent J. O'Conor, Jr.:** I think the important teaching point is that this child's pediatrician was living under the old philosophy which we were formerly taught—wait and see if the testes will come down at puberty and if they don't come down at puberty, operate to bring them down. It has been well demonstrated in the last few years that these testicles should come down, preferably before school age. I think our aim and that of the Children's Hospital is to have testes descended before the age of five. There is a tremendous difference between a five-year-old and an 11-year-old testicle. This child had pubic hair, so he was getting gonadotropin stimulation and, therefore, giving gonadotropin injections, as we would in a younger child, would probably not be effective.

The main reason for doing this is that the incidence of tumor in undescended testes is still about 30 times greater than in normal testes. The medical students should be aware that this is the most common tumor in people in their age group.

**Dr. John Beal:** Dr. O'Conor, isn't there a fairly high incidence of inguinal hernia and hernial sac associated with undescended testicle?

**Dr. Vincent J. O'Conor, Jr.:** Yes, our routine approach in an inguinal testicle such as this is to find the hernia sac and peel it away from the cord structure. This does two things. It gives you more length for the vas by detaching it from its peritoneal attachment. Also, in doing the surgery, we go quite high laterally, making a small incision but going almost to the kidney to free the lateral attachments of the cord. You can get 6 or 7 cm of length without compromising the blood supply just by freeing those attachments. So in response to your question, yes, they almost all have indirect inguinal hernias.

**Dr. John Beal:** Doctor Michaels mentioned that if you can palpate an undescended testicle, an inguinal incision is feasible. However, if it is not palpable, a midline incision is employed. Aren't some of the testicles in an ectopic position; that is, they have come through the inguinal ring but they may lie somewhere under the fat and not in the scrotum?

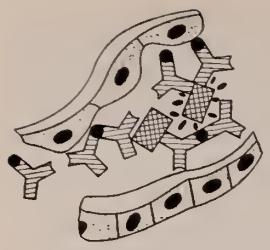
**Dr. Vincent J. O'Conor, Jr.:** Often the testicle can be located by direct pressure. Many of these children are fat for some reason. Our patient today was quite obese, but he knew when you were pushing on the area where the testicle was. Surgically, one other technical aspect which I think is interesting was described by Dr. Douglas Stephens, who is in our department at Children's. There are basically three arteries to the testicle: the main internal spermatic, the external one and the artery of the vas. If you are determining whether to sacrifice the main internal spermatic in order to get enough length to bring the testis down so it is in the scrotum without tension, you can clamp that one artery—the main internal spermatic—and then make a nick in the testis. If it doesn't bleed, you've cut off a great percentage of its blood supply. If it does bleed, then you can sacrifice that artery for the added length. ◄

---

## *Viewbox*

*(Continued from page 129)*

By means of a bolus injection of 50 cc of renografin 60, we are able to demonstrate with the use of a 5 second scanner the renal artery, opacified as is the renal cortical area with the columns of Bertin. Just above the site of the donor kidney is an area of radiolucency which is well circumscribed and about of water density. This was a post operative lymphocyst, which was evacuated surgically and is nicely demonstrated on C.T. examination.



# Seminars In Immunopathology and Oncology

Richard J. Ablin, Ph.D., Contributing Editor

# Immune Complexes and Human Disease

By Brian S. Andrews, BSc (Med) and Ronald Penny, M.D./Sydney, Australia

*This is the second of three parts in a special overview series for the "Seminars in Immunopathology and Oncology." In part one, Doctors Penny and Andrews delineated the historical background to immune complex research. This month's section, part two, explores detection of immune complexes. Part three, which considers general management criteria, will be published in the November* IMJ.

## Clinical Expression of an Immune Complex Disease

The clinical expression of an IC disease is related to the site involved in IC deposition and nature of subsequent tissue inflammatory reaction. In addition, ICs may mediate other immunopathological reactions. The mechanisms by which ICs can result in disease are indicated (Table 1). Circulating complexes may lodge on any vascular basement membrane, particularly those within the glomerulus (glomerulonephritis); skin (cutaneous vasculitis); uveal tract (uveitis); synovium (polyarthritis) and lung (pulmonary vasculitis). Systemic features which include fever and malaise are usually associated with the severity of the inflammatory process. Evidence of GN, a symmetrical polyarthritis and particularly the presence of inflammatory process in several tissue sites should alert the physician to IC-mediated tissue injury.

Local IC formation (Arthus reaction) occurs when Ag combines with an excess of circulating Ab in the vessel wall. In man this usually occurs after subcutaneous injection of antigenic material (*e.g.*, drugs, fungal extracts). It may also contribute, in part, to the immunopathology of extrinsic allergic alveolitis[52,53] and to a local reaction to gluten in the small bowel wall in coeliac disease.[54] The erythema nodosum leprosum (ENL) reaction in treated lepromatous leprosy has the hallmarks of both local (erythema nodosum) and systemic (uveitis, arthritis) IC reactions.[55]

On occasions, preformed complexes (especial-



BRIAN S. ANDREWS, BSc(Med), MB, BS, FRACP, is an assistant professar af medicine affiliated with the University af Virginia. He graduated MB BS, fram the University af Sydney Medical Schaal in Sydney Australia. Doctor Andrews is a fellaw af the Rayal Australian College af Physicians.



RONALD PENNY, M.D., F.R.A.C.P., F.R.C.P.A., is an assaciate prafessar af medicine and directar af the department af Immunalogy at the University af New Sauth Wales at St. Vincent's Haspital in Sydney, Anstralia. Doctar Penny initiated his research in immunology and immunopathology at the Institute af Cancer Research at New Yark's Calumbia University.

**Abbreviations**

| | |
|---|---|
| Ab | Antibody |
| Ag | Antigen |
| C | Complement |
| IC(s) | Immune Complex(es) |
| Ig | Immunoglobulin |
| GN | Glomerulonephritis |
| MPS | Mononuclear phagocytic system |
| PEG | Polyethylene glycol |
| PMN | Polymorphonuclear leukocyte |
| RA | Rheumatoid arthritis |
| RF | Rheumatoid factor |
| RIA | Radioimmune assay |
| SLE | Systemic lupus erythematosus |

**Table 1**

**Mechanisms by which Immune Complexes Produce Disease**

1. Deposition of circulating complexes on vascular basement membranes
2. Local IC formation[a]
3. Inhibition of normal immune responses
4. Passive adsorption of complexes to cells
5. Hyperviscosity

[a]Either local antigen release or primary fixation of antigen with secondary binding of antibody.

**Table 2**

**Evidence for an Immune Complex Disease**

1. *Clinical Picture*—Specific entity: e.g. bacterial endocarditis, drug reaction
   —Systemic: glomerulonephritis, cutaneous vasculitis, uveitis, polyarthritis, pulmonary infiltrates
   —Local: intradermal inoculation, extrinsic allergic alveolitis
   —Others: "blocking factors" in malignancy, hemolytic anemia "bystander reaction."
2. *Evidence for circulating ICs*—direct: e.g. Raji cell RIA, $^{125}$Clq-PEG, mixed cryoglobulins
   —indirect: e.g. complement activation
3. *Evidence for tissue ICs*—deposits of immunoglobulin and complement
   —staining or elution of antigen and/or specific antibody
   —electron dense deposits

ly drug related) absorb to the surface membrane of circulating red cells or platelets. This results in premature destruction following C activation ("bystander reaction").[56] Stibophen, phenacetin and quinine may thus result in hemolytic anemia and quinine in thrombocytopenia. Tumor Ag-Ab complexes[57] (one type of "blocking factor") in Ag excess may inhibit the immuno-elimination of malignant cells. This occurs when it either blocks T cell activation by tumor Ag or activates suppressor T cells; saturates the surface of accessory cells, *e.g.*, mononuclear phagocytes; binds to lymphocytes' Fc receptor leading to C activation and cell lysis; inactivates B cells by cross-linking their surface receptors; or alters the lymphocyte traffic pattern. In addition, ICs in Ab excess may mask tumor Ag or inhibit antibody-dependent cellular cytotoxicity.[52]

Immune complexes may increase whole blood and plasma viscosity and lead to aggregation of erythocytes particularly in the microvasculature. Less frequently, high concentration of ICs may produce massive systemic hyperviscosity.[58]

As indicated earlier, the clinical picture should be consistent with an IC disease but in addition ICs should be demonstrated both in serum and in tissues (Table 2).

## Detection of Immune Complexes

### (A) Serum

Numerous techniques have been employed in the detection of ICs in serum (Table 3).[35,59] However, the majority of these are nonspecific and may be associated with false positive and false negative results. Isolation and quantitation of mixed cryoglobulins is a similarly simple and direct method for identifying circulating ICs as it allows ready assess to Ag and Ab within the isolated cryoglobulin.[60] Anti-Ig's (rheumatoid factors) are again evidence of circulating ICs.[61]

A recent multicentric WHO study[62] considered the Raji cell RIA.[63] The study employed a B-type Burkitt lymphoma cell line possessing C and Fc receptors and capable of binding the fixed C components, C3d, C3b, and C1q, and to a lesser extent IgG by its Fc region. Results indicated that it appeared to be the most sensitive and specific single method currently available for measuring ICs in serum. The $^{125}$I Clq-PEG RIA also rated highly.[62] Neither assay quanti-

**Table 3[59-82]**

**Methods for Detecting Immune Complexes in Serum**

A. *Based on Physical Properties*
   1. *Size*—sucrose density gradient and analytical ultracentrifugation, gel filtration, ultrafiltration
   2. *Solubility*—cryoprecipitation[b], euglobulin, PEG precipitation
   3. *Charge*—anion exchange chromatography

B. *Based on Reactivity with Soluble Factors*
   1. *Complement*—anticomplementary activity[b], inhibition of latex agglutination by Clq, Clq precipitation, Clq binding (solid phase or PEG)[b], Clq deviation
   2. *Rheumatoid factor*—RF precipitation, RIA employing monoclonal or polyclonal RF, inhibition of latex agglutination by RF
   3. *Conglutinin RIA*

C. *Based on Reactivity with Cellular Receptors*
   1. *Fc*—platelet aggregation, inhibition of IgG-EA rosette formation, inhibition of antibody-dependent cell mediated cytotoxicity, macrophage RIA
   2. *Complement*—Raji cell RIA[b]

C. *Nonspecific Methods*
   1. Release of histamine from guinea pig lung preparation
   2. PMN chemotactic activity in plasma
   3. Increased PMN metabolic activity following ingesting of complexes

[b]Clinically the most useful and sensitive tests

tates ICs directly but rather the equivalent amount of heat-aggregated IgG that would be representative of the ICs in serum. Problems arise, however, with standardization of the aggregated IgG preparations. Raji cells have now been employed (a) to identify specific Ag and Ab in the membrane-bound complexes using fluorescein or isotope labelled antisera and (b) to isolate, elute and characterize the Ag and Ab in the complex.[57,64] By employing this approach, meaningful knowledge will be gathered about structure and characteristics of circulating ICs.

In several studies where a variety of IC-detecting methods have been compared, a poor correlation has been found.[15,49,65] Specifically, this seems to occur where different functional properties of the IC have been exploited by the methods. Thus, while some correlation apparently exists between the Raji cell RIA and the Clq-PEG binding assay[62] in which the ability of the IC to activate and bind C components is tested, there may be a poor correlation when assays employing RF or based on Fc receptor binding are compared (Table 3). Rather than indicate that one test is more specific or sensitive, it may be an equally valid interpretation to state that a spectrum of ICs with different properties circulates with either the same or different Ag's and/or with Ab's of varying affinities. Thus a variety of techniques which employ different functional properties of the ICs may differentiate between different IC systems in a specific patient.

### (B) Tissues

Immunoglobulin and C components and specific Ag and Ab may be demonstrated in tissues using either fluorescein or isotope labelled antisera,[83] elution techniques,[84,85] and electron microscopy where electron dense deposits suggestive of tissue ICs may be demonstrated.[86]

## Mixed Cryoglobulins

Mixed cryoglobulins contain serum Ig's which reversibly precipitate in the cold.[60,68] They represent circulating ICs and contain as Ab either a monoclonal protein, usually IgM (type II), or a polyclonal protein, IgM or IgG (type III), all with antiglobulin (RF) activity and with reactivity directed against the Fc region of polyclonal IgG.[68]

Cryoglobulin levels in normal individuals may reach 110 $\mu$g/ml.[60,65] Values in excess of 1,000

μg/ml occur in autoimmune inflammatory disease but in excess of 5,000 μg/ml are restricted to a monoclonal cryoglobulin (type I), usually associated with lymphoreticular malignancy.[68] Specific Ag-Ab systems commonly recognized in mixed cryoglobulins include IgG-IgG or IgM RF, DNA-anti DNA and hepatitis B-antihepatitis B.[60,87-92] Cryoglobulins may play a protective role by aiding IC elimination but overall evidence suggests that cryoglobulins play a pathogenic role. This is based on (a) skin and glomerular lesions in SLE and essential mixed cryoglobulinemia, and skin in cutaneous vasculiti containing identical Ig classes to those in the cryoglobulin;[92,93] (b) production of identical clinical and histological lesions in experimental animals and man following intradermal and intravenous injection of the isolated cryoglobulin;[94,95] (c) anticomplementary activity of the isolated cryoglobulin[95] and (d) removal of the cryoglobulins, and possibly other deleterious agents, by plasmapheresis resulting in disease remission.[58,96] The exact mechanism whereby cryoglobulins precipitate is not clearly understood.[60]

## Human Diseases Associated with Circulating Immune Complexes

### (A) Glomerulonephritis

Over 85% of human GN appears to have an immune basis with the majority assumed to be related to IC deposition. However, a small percentage is associated with specific glomerular basement membrane Ab's which result in nephrotoxic nephritis, Goodpasture's syndrome and some cases of rapidly progressing GN.[97]

The similarity between the renal lesion of experimental chronic serum sickness, in which glomerular Ag and Ab can be readily demonstrated and human GN and the frequent occurrence of GN in IC-mediated diseases, *e.g.*, SLE, suggest that IC deposition forms the basis of many cases of human GN.[98]

Light microscopic examination following IC deposition may reveal prominent mesangial cells (fixed mononuclear phagocytic cells containing Ig and C) and/or thickening of the glomerular basement membrane and capillary walls (associated with "lumpy-bumpy" or nodular deposition of Ig and C) together with a variable cellular infiltrate and fibrin deposition. Silver stains demonstrate spikes which are continuous with a thickened basement membrane. The area between the spike on the epithelial side contains electron dense deposits felt to represent ICs.[97,99]

In the majority of patients with IC-mediated GN, activation of C occurs predominantly via the classical pathway with demonstration of C1q, C4, C2 and C3 within the glomerulus.[101] To clearly identify alternative pathway activation, properdin factors B and D should be demonstrated in association with C3.[100] *De novo* activation of the alternative pathway may be produced by endotoxin, IgA containing ICs or initiating factor (IF) or secondary to classical pathway activation.[37]

After depositing on basement membranes, complexes may continue to bind Ab to free antigenic sites. This could increase the size of the tissue complex and mask antigenic determinants while simultaneously increasing its phlogistic potential.[99] DNA may bind *de novo* to collagen with binding of Ab the secondary event.[102] C3b receptors found on glomerular epithelial cells may represent a further mechanism whereby ICs with fixed C3b may localize to the glomerulus.[21,22]

Although specific Ag and Ab activity has been demonstrated within glomeruli by immunofluorescent and elution techniques,[85,99,100] this remains the exception rather than the rule (Table 4). Many are single case reports. Frequently identified Ag's have included DNA, streptococcus, staphylococcus and hepatitis B. In the future, glomerular pathology associated with malignant disease may be more frequently recognized.[103] As evidence of circulating ICs, mixed cryoglobulins have been demonstrated in the GN associated with streptococcal infection, bacterial endocarditis, serum sickness and the nephrotic syndrome associated with Plasmodium malariae infection.[108] In addition, ICs have been identified in GN sera by both the Raji cell radioimmune assay and a C1q binding assay.[109]

### (B) Systemic Lupus Erythematosus

SLE is associated with numerous autoimmune phenomena and is the prototype of a spontaneously developing human IC disorder.[110] Similar immunopathologic processes develop both in the

Table 4[97,99,103-107]

**Antigens Incriminated in Human Immune Complex Glomerulonephritis (GN)**

| *Primary Disease* | *Exogenous Antigens* |
|---|---|
| Acute proliferative GN | Hemolytic streptococcus |
| Infected ventriculoatrial shunt | Staphylococcus albus, Corynebacterium bovis |
| Bacterial endocarditis | Enterococcus |
| Pneumonia | Streptococcus pneumoniae |
| Secondary syphilis | Treponema pallidum |
| Serum sickness | Foreign proteins, drugs, inoculations |
| Typhoid fever | Salmonella typhi |
| Malaria | P. malariae, P. falciparum |
| Toxoplasmosis | T. gondii |
| Schistosomiasis | S. mansoni |
| Hepatitis, mixed cryoglobulinemia | Hepatitis B virus |
| SSPE, ?SLE | Measles virus |
| Burkitt's lymphoma | Epstein-Barr virus |
| Leukemia, ?SLE | Oncornavirus |
| | *Endogenous Antigens* |
| SLE | Nuclear, Ig, lymphocyte membranes (?) |
| Mixed cryoglobulinemia | Ig |
| Thyroiditis | Thyroglobulin |
| Sickle cell anemia, membranous GN (Japan), renal carcinoma, Fanconi syndrome | Renal tubular cell |
| $\alpha$-1 antitrypsin deficiency | $\alpha$-1 antitrypsin |
| Melanoma | Melanoma cell |
| Lung carcinoma | Tumor cell |
| Colonic carcinoma | Carcinoembryonic antigen |

New Zealand and Black/White Fl mouse and two recently developed strains, the BXSB and the MRL/l.[7] SLE is characterized by excessive Ab production (B-cell overactivity) against non-self (viruses) and self-components (cellular and non-cellular).[110] Impaired T-cell function possibly related to a decrease in suppressor T-cell activity has been proposed.[110,111] No consistent HLA pattern has been identified in lupus patients, although the disease occurs more frequently in twins, family members, and those with genetically determined deficiencies of C components (particularly C2 deficiency).[112] While genetic factors appear to be related, the disease may be polygenetic in its expression or influenced by genes which code for the immune response.[113] Although oncornaviruses can be readily demonstrated in the murine models of SLE, there is at present no definite evidence to suggest they play any role in the immunopathogenesis of human SLE.[114]

Antinuclear antibodies are the hallmark of the disease. The LE cell phenomenon is produced by Ab's which bind DNA histone.[115] Double stranded, native DNA (dsDNA) and single stranded, denatured DNA (ssDNA) may circulate but under normal circumstances are readily cleared by an intact MPS without an increase in Ab production.[116,117] However, in SLE, DNA elicits a significant Ab response[116,117] suggesting either that lupus DNA is foreign and not entirely host in origin; that an antigenic alteration has occurred, or that Ab production is related to impaired suppressor T-cell activity. Sun exposure releases UV-denatured DNA into the circulation,[118] frequently exacerbating SLE and associated with Ab formation to dsDNA, ssDNA, and occasionally ribonucleoprotein. Addition of DNase to lupus serum may increase the DNA antibody titer suggesting that DNA circulates as an Ag-Ab complex.[119] The diagnostic antinuclear fluorescent pattern is the peripheral pattern, indicating Ab's against dsDNA and usually associated with active lupus GN. Antibodies against DNA histone are responsible for the homogenous nuclear staining and are present in high titers in active SLE and occasionally other connective tissue disorders.[120] A strongly positive LE cell preparation is usually confined to active SLE with the exception of severe rheumatoid vasculitis.[120] Antibodies against the nuclear glycoprotein Sm result in a speckled nuclear strain. It was recently suggested that these are more diagnostic of SLE than those against dsDNA.[121]

In active SLE, ICs consisting of dsDNA-anti dsDNA, ssDNA-anti ssDNA and ssDNA-anti dsDNA appear to be pathogenetic.[122,123] Rising Ab titers to dsDNA, a fall in serum C and high MW C1q precipitable complexes are associated with active nephritis.[70] Low MW C1q precipitable complexes are associated with C activation but not with clinical nephritis.[70] The nature of the low MW complexes is not understood. They may represent binding of C1q to lymphocyte membrane components[87] or free DNA in serum.[70]

Mixed cryoglobulins circulate in active SLE,[70,124] require C1q for precipitation and usually contain IgG, C1q, and RF.[124] Cold reactive IgM anti-lymphocyte Ab's are concentrated in cryoprecipitates, possibly complexed with lymphocyte membrane components.[87] The role of IgG warm reacting anti-lymphocyte Ab's in SLE awaits clarification.[125]

Evidence indicates that circulating ICs can produce tissue damage in SLE.[92,110,123] Immunoglobulin and C can be found within the glo-

merulus and coincide with electron dense deposits.[84,99,126] Nuclear Ag's including DNA together with their respective Ab's and RF have been identified by immunofluorescent and elution techniques in the kidney[84,127,128] and correlate with the components within the circulating complexes, especially cryoglobulins.[92] High affinity DNA antibodies are preferentially localized in the tissue ICs while low affinity antibodies appear to predominate in serum.[129]

During active cutaneous SLE, Ig, C and electron dense deposits are found at the dermoepidermal junction and in the walls of dermal capillaries in involved skin. They are found in uninvolved skin in up to two-thirds.[130] While vessels in the choroid plexus in "cerebral lupus" may contain Ig and a reduction in CSF C4 and elevated CSF IgM levels have been reported, the exact immunopathologic basis for this remains unclear.[131,132]

Clinical improvement following corticosteroid therapy is accompanied by a fall in DNA Ab titer, a rise in serum C, and the disappearance of mixed cryoglobulins, RF, and C1q precipitable complexes from serum.[110,120,127] Although oncornaviruses can be readily demonstrated in the murine models of SLE, there is at present no definite evidence to suggest they play any role in the immunopathogenesis of human SLE.[114]

### (C) Rheumatoid Arthritis (RA)

Classical RA is a systemic inflammatory disease characterized by symmetrical, erosive polyarthritis and accompanied by agglutinating IgM RF in serum.[120] In early disease, the synovium is infiltrated with lymphocytes[133] with the synovial fluid containing increased numbers of T and null cells[134,135] and lymphokines.[136,137] Macrophage migration inhibitation factor (MIF)-like activity has been demonstrated in synovial fluid, in the supernatant from cultured synovial membranes and in the supernatant following incubation of leukocytes from RA patients with aggregated IgG.[136,137] In later disease, the lymphocyte population in synovial fluid is replaced by PMNs.[136] Recent studies have suggested that damage to the synovial membrane and cartilage may be mediated by collagenase which may be activated by the local joint fibrinolytic system.[138] The presence of HLA-DW4 in 59% of caucasian RA patients compared with 16% in normal caucasian controls suggests that a gene(s) in the HLA-D region may influence the immune response gene in this disorder.[139]

Antiglobulins or RFs are autoantibodies (IgM, IgG and IgA)[140] directed against the Fc region of both monomeric and aggregated IgG.[141] These antibodies are present in low titers in the serum of aging normals and in higher titers in other connective tissue diseases (Sjögren's syndrome, SLE) and infectious processes (hepatitis B, bacterial endocarditis, syphilis, leprosy, TB, malaria).[136] IgM antiglobulins represent the classical 19S rheumatoid factor; bind to 7S IgG; circulate as a 22S complex and are responsible for the positive RF (latex) test.[61,66] IgG RF binds to IgG resulting in smaller complexes (10-19S) which are present in rheumatoid serum and synovial fluid.[66,74,136] IgA rheumatoid factor can be detected in seropositive and negative RA but its pathologic significance remains unclear.[140] It has been proposed that IgG RF binds to autologous IgG resulting in a C-fixing IC. When IgM RF is present, this binds to the IgG-IgG RF complex leading to an increase in size and further C activation.[136,142]

Several theories have been proposed to account for antiglobulin production.[136] The first proposes that IgG becomes antigenic following binding with Ag, *e.g.*, virus. Recent biochemical analysis of IgG from RA patients adds support to this theory with a structural change noted in the Fc region of the IgG molecule.[143] The second proposes that B cells, which are normally tolerant and synthesize small quantities of antiglobulin are able to proliferate and escape from tolerance.[136] This may result from loss of suppressor T-cell or increased helper T-cell activity following binding of Ag or Ag-Ab complexes.[144,145] Activated C3 or lysosomal enzymes liberated from phagocytic cells may also enhance Ab production by B-cells.[146] Experimentally, RF may be generated by repeated injections of heat-killed bacteria, which suggests that RF represents a response to chronic antigenic stimulation.[147]

The predominant IC in rheumatoid synovial fluid is an IgG-IgG RF complex (soluble, C fixing) which is phagocytosed by PMNs and synovial lining cells (types A and C). This process is enhanced by further binding of IgM-RF to the IgG-IgG RF complex.[136,148,149] Synovial fluid complexes readily fix C,[148] produce PMN chemotactic factors, (especially C5a and C567*)[150] are

**The asterisk indicates the activated state of the molecule. (Standard World Health Organization Nomenclature is a bar over the molecular symbol. Because reproduction of this nomenclaure was not feasible, the bar is herein represented by an asterisk.)*

phagocytosed by PMNs leading to release of lysosomal enzymes and are precipitated by both Clq and IgM RF.[151,152] Cryoprecipitates within synovial fluid are anticomplementary and contain varying proportions of IgG, IgM, DNA, and antinuclear antibodies.[148] Vasculitis in sero-positive RA, associated with circulating IgG-RF and 7S IgM,[153] appears to be related to deposition of circulating ICs in the disease.[58,148,149,154]

Regardless of the initiating agent in RA, local joint IC formation appears to play a major role in the immunopathology of RA. Occasional pathogenic ICs may be demonstrated in serum usually in association with a vasculitic process.[148,149]

### (D) Cutaneous Vasculitis

Acute hypersensitivity or leukocytoclastic vasculitis is an inflammatory process primarily involving the capillary-venular vascular bed within the dermis.[31,38,155] The cellular infiltrate occurs both in and around damaged vessel walls.[155] While palpable purpura is a diagnostic feature,[155] a polymorphic cutaneous eruption strongly suggests a vasculitic process.[49] This entity may be accompanied by polyarthritis, GN[156] and, in our experience, hepatic involvement.[49]

Etiologic factors consist of infectious agents, (hepatitis B, herpes simplex, vaccinia, streptococcus) drugs, (penicillin, sulfonamides, thiazides) liver disease, (alcoholic, auto-immune) connective tissue disorders (RA, SLE) and malignancy.[23,49,157] In our recent study of 53 patients presenting with cutaneous vasculitis,[49] an infectious etiology was defined in 10, exposure to drugs and chemicals in 12, liver disease in six, and a connective tissue disease in eight.

The histology of cutaneous vasculitis may resemble an Arthus-type reaction.[158] In the former, a PMN infiltrate may persist for three-four days unlike the 24-hour evanescent infiltrate of the Arthus reaction.[31,159] In our experience as well as others, a lymphocyte predominant cellular infiltrate may be found in this patient group.[48,49] Tissue ICs were demonstrated in 40% of the lymphocyte predominant group compared with 68% in the PMN predominant.[49]

Mixed cryoglobulins have been demonstrated in one-third of patients[49,93] with the identical Ig class found in the vessel wall.[93] Clq precipitins,[160] hypocomplementemia,[161] and anti-complementary activity[69] in serum are further evidence for circulating Ic's. In our study[49] we reported mixed cryoglobulins in 40%, Clq precipitins in 8%, anticomplementary activity in 37%, C activation in 30%, RF in 17% and PMN chemotactic activity in plasma in 72%. Demonstration of Ig and C components[162,164] and electron dense deposits in dermal vessels are highly suggestive of IC deposition,[165] although specific Ag and Ab activity have been identified on occasions.[166]

**Table 5[c]**

**Human Disorders Associated with Circulating Immune Complexes**

| | |
|---|---|
| *Rheumatologic* | — SLE, Polyarteritis (Hepatitis B), RA, cutaneous vasculitis, mixed cryoglobulinemia, serum sickness, Wegner's granulomatosis. |
| *Ocular* | — Uveitis, retinal vasculitis |
| *Renal* | — Glomerulonephritis |
| *Malignant Disease* | |
| *Endocrine* | — Autoimmune thyroid disease |
| *Infectious* | — Bacterial: Staphylococcus, Streptococcus, S. Typhi, T. pallidum<br>Viral: Hepatitis B, Epstein-Barr, Cytomegalovirus, Dengue virus<br>Protozoal: Malaria, Trypanosomiasis<br>Worms: Onchocerciasis, Schistosomiasis |
| *Gastrointestinal* | — Ulcerative colitis<br>Crohn's disease<br>Coeliac disease<br>Acute and chronic liver disease |
| *Miscellaneous* | — Post kidney transplantation<br>Dermatitis herpetiformis<br>Dressler's syndrome<br>Extrinsic allergic alveolitis<br>Sarcoidosis<br>Drug reactions<br>Atherosclerosis (?) |

[c]15, 35, 49, 52-54, 57, 59, 61, 63, 65, 68, 74, 81, 89-92, 97, 103, 123, 127, 148, 167-181

### (E) Miscellaneous

As with GN, preferential tissue deposition of IC's may result in uveitis[15] and retinal vasculitis,[65] although both conditions may represent a manifestation of a systemic inflammatory process. Infectious diseases (Table 5) are frequently associated with circulating and tissue ICs. Complexes may further modify the immune response associated with elimination of the organism. Many blocking factors which limit the immune rejection of tumor cells appear to represent tumor Ag-Ab complexes.[35,57] While a local Arthus reaction may partly account for the im-

munopathologic process involved in coeliac disease or extrinsic allergic alveolitis, *e.g.*, pigeon breeders disease, this is far from established.[52,54] Circulating lipid-antilipid complexes have been speculated upon in the pathogenesis of atheroma.[171,172] ◄

---

*This concludes part two of our three part series on immune complexes and human disease. Part three is scheduled for the November issue. A complete list of references is available upon request to: Illinois Medical Journal, 55 E. Monroe, Suite 3510, Chicago 60603.*

---

## *Support Your Advertisers*

---


**PHYSICIANS**

**General Practice** **Family Practice**
**Internal Medicine** **Radiology**

Our JCAH accredited hospital is located in a scenic midwestern community, within one hour of a major metropolitan area. Practice opportunities are available to qualified physicians in the above listed specialties.

For further information, submit your Curriculum Vitae in strictest confidence or contact:

Director, Physician Relations
MEDENCO HOSPITALS Inc.

**P.O. Box 3448**
**Houston, Texas 77001**

**1-800-231-2855**
**(713) 621-8131 (within Texas)**

**LOW-COST GROUP INSURANCE ANOTHER ISMS MEMBERSHIP PRIVILEGE**

**THE GROUP DISABILITY PLAN** ● Provides up to $1,732.00 monthly in the event of disability caused by Accident or Sickness. ● Special Guaranteed renewal feature. ● Protect your income and security.

**BUSINESS OVERHEAD EXPENSE PLAN** ● Pays your office overhead expense when disability strikes. ● Premiums are Tax Deductible. ● Pays in Addition to the Disability Plan Benefits.

**THE BASIC MAJOR MEDICAL EXPENSE PLAN** ● In or out of Hospital Benefits up to $25,000.00 per Disability. ● Up to $100.00 Daily Hospital Room and Board maximum. ● Subject to choice of deductible and 80% coinsurance.

**EXCESS MAJOR MEDICAL PLAN** ● Provides up to $500,000 for Medical Expenses. ● Supplements any Basic Major Medical Plan and is available with a $15,000, $20,000 and $25,000 deductible. Low group rates. ● Truly catastrophic coverage.

FOR INFORMATION, ASSISTANCE & DETAILS CONTACT:

Administrators:
PARKER, ALESHIRE & COMPANY
ESTABLISHED 1901
Insurance

**9933 N. Lawler Avenue**
**Skokie, Illinois 60077**
**Phone: 312-679-1000**



# membership forum

*Membership Forum is intended to serve as a communicative tool for ISMS Membership. The Editors encourage comment and criticism on issues of the day. Material published in this section reflects the personal opinions of individual ISMS members. The Editors cannot accept responsibility for content. Publication does not reflect official policy or position of the Illinois State Medical Society or the Illinois Medical Journal. The right to edit materials, which should be limited to 300 words or less, is reserved.*

*Correspondence should be addressed to: IMJ, 55 E. Monroe, Suite 3510, Chicago 60603.*

*In response to Resolution 78A-19, approved by the ISMS House of Delegates at the Annual Meeting in April, members have been requested to report "in truthful and timely basis unfavorable experience with third-party payors so that these experiences can be published in the IMJ Membership Forum, over the signature of the individual physician." ISMS members are encouraged to participate in this communicative effort.*

## The Selective Blindness of the Secretary of HEW

It is curious that the Secretary of HEW finds so much to admire in the British National Health Service when people who are much better fitted to judge find exactly the opposite! Lord Arthur Porritt, who has been surgeon to Queen Elizabeth for 25 years, wrote to me recently after an article of his was published in the Journal of Legal Medicine. "I felt that since over the years I have been lucky enough to glean a great deal from American surgeons and surgery the least I could do was to warn them not to tread the rather sad path we had in the United Kingdom," he said.

Mr. Califano's selective blindness extends to the evidence presented by the Royal Commission on the National Health Service of Great Britain in a publication dated April, 1977. On page 5 in Chapter II this statement appears on the quality of the service. "The National Health Service is failing to provide the quality or quantity of service which the patients have been led to expect—if this country cannot afford a Comprehensive Health Service, the limits of the National Health Service should be clearly defined."

Since most Royal Commissions function to whitewash a nationalized industry or profession, this candid admission of failure must carry tremendous weight. It would be interesting to know if any of the HEW staff had read this valuable piece of objective reporting. It was published by the British Medical Association, BMA House Tavistock Square, London, WC1H 9JP and printed by J. E. C. Potter & Son Ltd., Stamford, Lincs.

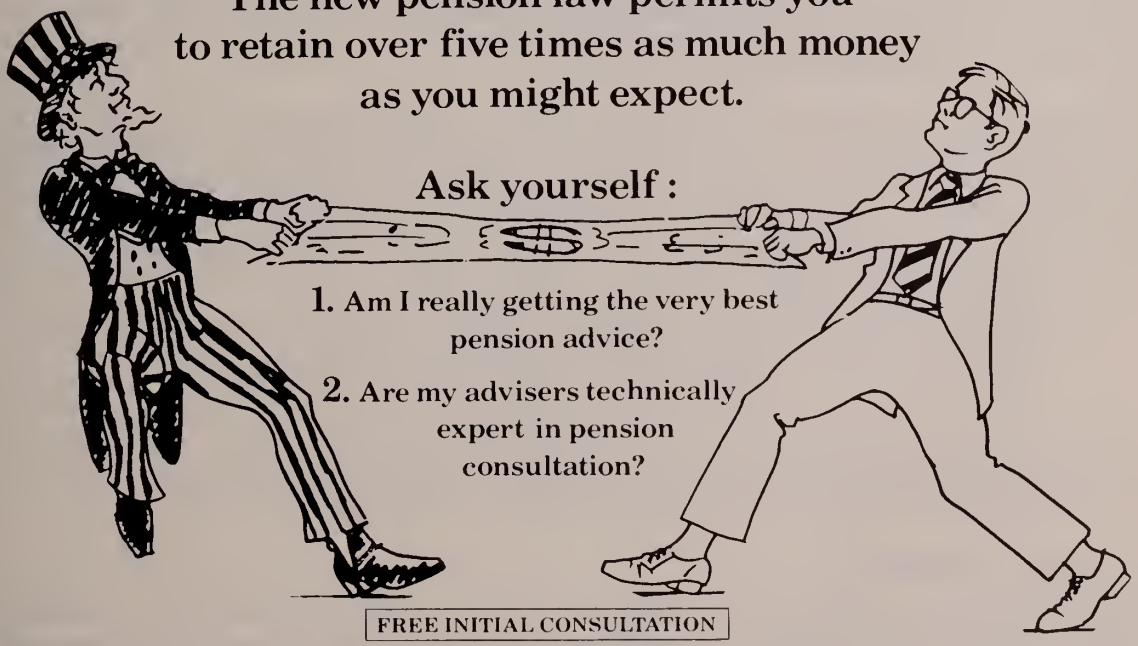
If there is any one group with which the Secretary of HEW should pursue harmony it surely should be the medical profession. This in no way means that he must approve everything that doctors do. His efforts to eliminate Medicaid and Medicare fraud (where indicated) are totally justified. But the manner in which this is finally released to and reported by the media is calculated to do more harm than good to the delicate relationship which exists between the Secretary and the medical profession. Good doctors, it would appear, are taken for granted; fraudulent doctors are news and their sins are excellent topics for righteous editorials. The public, without suitable information, cannot be expected to know that doctors are paid at their 1971 fee profile level for Medicare patients. Nor would they know that doctors are lucky to receive any more than 65% of their usual, customary and reasonable fees for Medicaid patients. Mr. Califano knows these facts and so do the governors of the states, but the thirty lashes for fraudulent practices are not accompanied by any qualifying information of this kind. A simple statement of the facts and a public expression of thanks to the vast majority of dedicated doctors would do much to create an atmosphere for constructive progress toward optimal use of the health dollar.

There is a very real risk that many honest physicians will be so upset by Mr. Califano and his computer-powered drive that they will simply refuse to see Medicaid or Medicare patients. HEW has already issued erroneous lists of doctors and the amounts of money they have reputedly received from Medicare and Medicaid sources. Scarcely a blush has crossed the cheek of HEW. The closest they have come to an apology or disclaimer is the statement that this was not exactly a human error. It was a "computer error."

Let us be absolutely clear on one point. To the good, average physician a sick patient is a sick patient regardless of how he intends to pay. The Medicaid patient sits on the same seat, receives the same consideration, is examined for the same length of time, and is afforded the same quality of medical care as any other patient. To their everlasting credit, most doctors are not even aware of which "type" of patient they are treating. Low pay, slow pay, no pay—these everyday Medicaid failings may irritate but they do not turn off the medical profession. One thing that does, however, is the insinuation that all doctors are guilty of fraud and that the drive launched against fraud is launched against the whole profession. Perhaps it would be wise for the Secretary of HEW to obtain some suitable lenses for his selective blindness. He might then see things as they really are and not as he imagines them to be, either here or in Great Britain.

James W. Sutherland, M.D.
Ch. M. (Hons) Glasgow
FRCS. Eng., FRCS. Ed.


**The new pension law permits you to retain over five times as much money as you might expect.**




FREE INITIAL CONSULTATION

American Society Pension Actuaries
Consultants to the Chicago Medical Society Employees Pension Plan
National Association Pension Consultants

Mann, Levine & Weiss, Ltd. 3525 W. Peterson, Chicago, IL 60659

(312) 539-7820 Pension Consultants and Plan Designers (312) 539-7820

# *Abstracts of Board Actions*

*(Continued from page 120)*

## Risk Management

A Risk Management Committee was created under the Task Force on Professional Liability to stimulate hospital medical staffs to develop innovative loss prevention programs. As an initial step, modest subsidies will be awarded to foster up to six demonstration risk management programs developed by medical staffs. The new Committee also will: (1) Oversee work on special claim flyers that summarize cases from actual claim files as a form of physician education; and (2) Establish mechanisms for extracting, digesting and disseminating to physicians useful information (such as loss data, policies and procedures for controlling risks) secured through the demonstration medical staff programs. Funding for Committee activities will be provided jointly by ISMS and ISMIS.

Physicians named to the Committee were: Richard Wilbur, Lake Forest, chairman; Earl Dordal, Peter McKinney and Melvin Post, all of Chicago; Fredric Lake, Evanston, chairman of the Task Force on Professional Liability; and Phillip Boren, Carmi, medical director of ISMIS.

## Jail Health Project

ISMS has recommended that AMA accept the following county jails for participation in the AMA Jail Health Program—administered in Illinois by ISMS: Adams, Kane, Peoria, Winnebago and Sangamon.

Overall direction and technical assistance to help the jails meet the AMA's Standards of Accreditation will be provided by a State Technical Advisory Council (STAC). Named to the STAC were: Drs. Robert Kramer, Joliet, chairman; Lee Johnson, Litchfield; and Joseph Winterhalter, Jacksonville. An additional physician member from the Chicago metropolitan area will be named based upon a recommendation from the Chicago Medical Society. The following organizations will be asked to appoint representatives: Ill. Nurses Assn.; Ill. Sheriffs' Assn.; Ill. Dept. of Public Health; Ill. Dept. of Corrections; Assn. of Administrators of Ambulatory Services; Ill. Pharmaceutical Assn. and Ill. State Bar Assn.

## Interim House of Delegates Meeting

The Board will introduce a resolution at the November House of Delegates session calling for a bylaws revision that would streamline interim House of Delegates meetings beginning next year. The resolution—resulting from a study directed by the House—would limit business considered at the interim session to:

- Resolutions and information reports introduced by the Board of Trustees as urgent business.
- Resolutions introduced by the chairman of the AMA Delegation on matters of national importance and considered urgent.
- Resolutions introduced by individual delegates if accepted by the Committee on Rules and Order of Business which would base its decision to accept or reject a resolution on the urgency of its subject. The decision of the Committee could be overruled by a 2/3 vote of the House. If not accepted, resolutions would be postponed until the annual meeting.

Members of the Committee on Rules and Order of Business would be nominated by the House Speaker and confirmed by the House to serve one-year terms with no limit placed on the number of terms each member could serve.

## Choke-Saving Technique

ISMS will urge the Illinois Department of Public Health to initiate changes in a poster—being distributed to restaurants statewide—outlining recommended "choke-saving" methods. While the Society will voice support for the techniques illustrated, it will recommend that the poster be simplified and also produced in foreign languages. Under the Illinois choke-saving law, IDPH is required to adopt and publicize the emergency procedures.

## Midwifery

ISMS will protest any Illinois Department of Public Health permission allowing hospitals to conduct "pilot projects" in which midwives perform obstetrical services in uncomplicated deliveries. The Society will: (1) Voice its opposition to midwifery; (2) Point out that such projects violate statutes prohibiting the practice of midwifery; and (3) Emphasize that in the interest of patient well-being, obstetrical care must be under the direction of a physician.

## Doctor's Job Fair

ISMS will sponsor a seventh annual Doctor's Job Fair on December 10. The Illinois Association of Osteopathic Physicians and Surgeons will be invited to co-sponsor the program.

## 'Death Awareness' Seminar

ISMS and Illinois Funeral Directors Association will co-sponsor a program entitled Death Awareness Consortium on September 20, at McCormick Place, Chicago. Topics will include: "Sudden Death: Facilitation of Mourning for People of All Ages"; "Vulnerability of the Care Giver"; "Grief and a Wholistic Approach to Health Care"; and "Isolation and Human Contact." Registration fee for the 9:30 a.m.-4:30 p.m. session is $12 for the seminar and $18 for the seminar and luncheon.

## Appointments/Nominations

Appointed to fill vacancies on ISMS councils and committees were:

- Dr. Garland Kirkpatrick, Chicago—Council on Medical Service
- Dr. Robert Knight, Bloomington—Council on Economics & Peer Review
- Dr. Edward Ference, Springfield—Council oi Governmental Affairs
- Dr. Ronald Sumner, Peoria—Public Affairs Committee
- Dr. Robert Fox, Glenview—Task Force on Cost Effectiveness
- Dr. Joseph Burke, Waukegan—Committee to Study Implementation of Resolution 78A-14 (PSRO)

Named to an ad hoc committee to study S 2755 and HR 11611—which would create a Drug Regulation Reform Act—were: Drs. Joseph Skom, Chicago; Vincent Costanzo, Chicago; B. Smith Hopkins, Champaign; and Robert Hartman, Jacksonville. Following a study of the bills, the committee will meet with the FDA District Director and HEW Associate Commissioner for Health Affairs to discuss implications of the legislation.

Nominated to fill vacancies on the IDPA Medical Advisory Committee were: Drs. Joseph Sherrick, Northbrook; Joseph Perez, Rockford; and Morris Friedell, and Raymond DesRosiers of Chicago.

Meeting as the individual administrative members of IFMC, ISMS Trustees reelected the current members of the IFMC Board of Directors for 1978-79: Drs. Joseph Sherrick, president; Robert Johnson, vice president; James Laidlaw, secretary-treasurer; Audley Connor, Miller Henderson and Lawrence Hirsch.

Dr. Warren Tuttle, Harrisburg, was elected to the ISMIS Board of Directors, replacing Dr. Joseph Bordenave, Geneva, who resigned.

The Board ratified the following actions of the Executive Committee:

- Designation of Drs. Willard Scrivner, Belleville, and Audley Connor, Chicago, as the Society's representatives on the Statewide PSRO Council.
- Nomination of Dr. James Williams, Chicago, for reappointment and Dr. Helen Beiser, Chicago, for appointment to the Department of Registration and Education's Medical Disciplinary Board.

Appointed ISMS representatives to the Illinois State Cost Containment Committee—a joint ISMS-Ill. Hospital Assn. group charged with implementing the Voluntary Effort to control health costs—were: Drs. David Fox, Chicago; Robert Fox, Glenview; Robert Hartman, Jacksonville; J. M. Ingalls, Paris; Clifton Reeder, Chicago; and P. John Seward, Rockford.

Drs. Brian Tugana and Donald MacLean, both of Rockford, were appointed to the Scientific Speakers Bureau of the Alcoholism Education Program.

# Physician Recruitment Program

*In an effort to reduce the number of towns in Illinois needing physicians, the Physician Recruitment Program and the Doctor's Job Fair, are publishing synopses in the Journal.*

*Physicians who are seeking a place to practice or who know of any out-of-state physicians seeking an Illinois residence are asked to notify the Program.*

*Any areas wishing to be listed should contact: Mrs. E. Duffy, Physician Recruitment Program, ISMS, 55 E. Monroe, Suite 3510, Chicago, 60603.*

*Announcing . . .*

## The 1978 DOCTOR'S JOB FAIR
## December 10, 1978
## Sheraton-OakBrook Hotel

*For further information contact:*

Physician Recruitment Program
Suite 3510 — 55 E. Monroe
Chicago, IL. 60603
312-782-1654

**ARCOLA:** Wanted-American trained F.P. to join established F.P. in active practice. Must do some O.B. Guaranteed salary and benefits. Eventual partnership. Robert N. Arrol, M.D., 126 S. Locust, Arcola, 61910. (217) 268-4444, or 268-4404. (12)

**ATKINSON:** Due to recent death of town's physician, a modern clinic with all facilities is available to a family physician who wants security and a wonderful place to practice. Hammond Henry Hospital only 8 miles away. Excellent grade and high schools and near Black Hawk Junior College. 30 miles to Quad City area, 140 miles to Chicago and 60 miles from Peoria. All recreational facilities nearby. CONTACT: John W. Ellis, Mayor, Atkinson 61235. (309) 936-7566. (12)

**AURORA:** Opening in General Internal Medicine with 40 man group. Complete office facilities. Good starting salary. Contact: L. E. Snyder, M.D., 1870 W. Galena Blvd., Aurora 60506. (312-859-6700) (1)

**CHICAGO:** Opportunities Available for Family Practitioners in a single specialty clinic setting. Association as a satellite facility with a 265 bed community hospital. Opportunity to build own practice with financial assistance available. Contact: Teryl R. Filebark, 1044 N. Francisco Ave., Chicago 60622. (312) 278-8800. (9)

**CHICAGO** (desirable suburb): Older general practitioner has excellent office facilities to share with younger G.P. Objective: need help with practice. Younger man may have guarantee to take over practice in near future. Hospital staff appointment available. All replies confidential. Box MK, Physician Recruitment Program, ISMS. (9)

**CHICAGO:** Major Chicago based retailer seeking corporate physician. Up-to-date, modern facilities, regular hours and comprehensive employee benefits make this a very desirable position. Please send resume with salary requirements. Contact: Professional Employment Director, Sears, Roebuck & Co., D/707-2, Chicago 60684 (1)

**ELGIN:** Psychiatrist, ¾ time position with CMHC. Provide leadership and direction of medical and psychiatric aspects of clinical program, consult with staff, provide direct service to a wide variety of patients. Experience: past residency, preferably Board certified. Resume and salary requirements would be helpful to: Jack Crook, Director of Programs, Fox Valley Mental Health Center, 384 Division, Elgin, 60120, (312) 695-1115. (10)

**FAIRBURY:** Population 3,500. Rural area serving a population of more than 16,000. Excellent practice opportunity for family practitioner or internist interested in family practice. Enjoy life and your practice in an area which offers excellent facilities and a personal, friendly atmosphere; join the staff of 112-bed JCAH accredited community hospital. Write: Frank Brady, Administrator, Fairbury Hospital, Fairbury, 61739, or call collect (815) 692-2346. (10)

**HARVARD:** An internist, OB-GYN for Northern Illinois commuter suburb. New hospital, good schools, guaranteed salary and benefits based on qualifications. Close to resort areas. A solid community economically. Contact: Dr. John P. Hill, 502 N. Hart, Harvard 60033. (815-943-5151) (1)

**LISLE:** Physician needed to assist me in handling my very extensive private family practice. Salary open, good opportunity for this relationship to merge into a partnership association. CONTACT: M. Sinkovits, 4513 Lincoln Ave., Lisle 60532. (312) 968-2735. (12)

**MACOMB:** GP-FP 12 month contract practice—University Health Service. Outpatient clinic—no OB, Surgery. Fringes include hospitalization, paid vacation, retirement, etc. Approximately 13,000 students, city 23,000. Competitive negotiable income. Equal opportunity affirmative action employer. Contact: C. E. Hughes, M.D., Director BEU Health Center, WIU, Macomb 61455. (1)

**MINIER:** General or family practitioner for rich agricultural area near Bloomington. Large practice waiting due to death of doctor. Office with X-ray and other equipment, very reasonable. Unusual opportunity. Contact: Harvey Graff, Minier 61759. (309) 392-2345 or 392-2120. (10)

**OSWEGO:** Family physician or internist to join group of four in a small town primary care clinic. Two full-service hospitals nearby. One hour west of Chicago. Dr. A. Haan, Oswego, 60543. (312) 554-8431. (11)

**OTTAWA:** Opening in fields of Internal Medicine and Family Practice with multi-specialty group of nine physicians. Community, 20,000 plus. 154 bed hospital under five years old. Latest equipment. One and one-half hours from Chicago and Peoria. Near State Parks. Excellent school system. Close to Jr. College and State Universities. Salary negotiable. CONTACT: Mrs. Van Buren, Ottawa Medical Center, 313 W. Madison, Ottawa 61350. (815) 433-1010. (10)

**PEORIA:** Economical sound central Illinois community of 250,000 situated in picturesque river valley has need for family physicians and general internists to practice in a 300 bed community hospital affiliated with the University of Illinois, College of Medicine. Office space and financial assistance available. "A GOOD PLACE TO PRACTICE GOOD MEDICINE." Contact: John A. Smith, Administrator, Proctor Community Hospital, 5409 N. Knoxville, Peoria 61614. (309-691-4702) (3)

**WAUKEGAN:** Population 67,000, northern Chicago Suburb. Newly remodeled medical center near hospital. Looking for Internist, Family Physician. Contact Washington Center, 1515 Washington St., Waukegan 60085, Y. Lee, M.D. 312-336-2221 or 729-5407. (9)

**WEST FRANKFORT:** Population 10,000, county 42,000. Coal mining growth area (1,200 new jobs). Offices available near hospital. On I57/24 in Southern Illinois. Major university near. Good highways, and recreation. Need OB-GYN, IM-CV, IM-GP and FP. Financial assistance. Contact: Wm. D. Palmer, Administrator, UMWA Union Hospital, 507 W. St. Louis St., West Frankfort 62896. (618-932-2155) (1)

★

*Specialized Service*

IN

PROFESSIONAL LIABILITY INSURANCE

*is a high mark of distinction*

THE

MEDICAL PROTECTIVE COMPANY

FORT WAYNE, INDIANA

*Professional Protection Exclusively since 1899*

CHICAGO AREA OFFICE:

T. J. Pandak, J. C. Kunches, L. R. Gannan, and W. G. Prangle, Representatives

814 Commerce Drive, Suite 101B, Oak Brook, Illinois 60521 (312) 325-7314

SPRINGFIELD OFFICE: W. J. Nattermann, Representative

426½ South Fifth Street, Springfield 62701 (217) 544-2251



# NHI Drive Hits Snag

The drive to a national health insurance has hit a formidable snag. President Carter's vaguely defined NHI strategy has suffered biting criticism by Senator Kennedy and labor leaders and created a sharp division among NHI backers.

The President's call for a gradual phase-in with no additional federal spending until 1983 has some observers convinced that comprehensive NHI has fallen victim to Presidential politics. It has been reported that Mr. Carter is using the issue to assert his independence and demonstrate that he cannot be manipulated by Senator Kennedy and organized labor. In any case, the President appears to have abandoned for the foreseeable future his commitment to NHI.

The campaign promise of NHI was attractive and politically expedient. Now it appears that political experience calls for a "go slow" approach. In addition to the Kennedy-Labor issue, support for NHI is evaporating in light of the multi-billion dollar price tag placed on so-called "free" medical care. The White House is beginning to realize that campaign promises are easier made than kept.

While a recent poll showed that 76 percent of the public apparently favors NHI, support dropped to 40 percent when the plan was tied to increased taxes. The possible ramifications of launching a tax-financed NHI program in a climate of taxpayer rebellion—signaled by California's Proposition 13—has affected Congress.

Reluctance to face election year consequences of a massive new spending program was evidenced by the lack of demonstrable progress of pending bills. When House Commerce and Senate Finance Committees defeated hospital cost control measures—labelled by administration officials as the cornerstone of NHI—backers of national health insurance conceded a severe setback. Lawmakers also are readily agreeing that Medicare and Medicaid are big contributors to the cost problem, and that unravelling this bureaucratic tangle should be the first step in government health initiatives.

Considering the split among NHI proponents, taxpayer hostility and the success of a Voluntary Effort in controlling costs, the short-run prospects of holding a line against NHI appear bright. What seemed inevitable and close at hand a short time ago now seems more distant and less certain.

In fact, our most dangerous adversary now is complacency. We must take advantage of this break-down in the NHI push to correct any defects in the present pluralistic health care system . . . and then demonstrate that it can survive and provide through open-market competition the best and most equitable medical care in the world. Our goals must be (1) cost containment without sacrifice of quality; and (2) assurance of accessibility to high quality care for all levels of society.

The current confusion in Washington sets the stage for a major debate on strategy within organized medicine. Should the AMA introduce a comprehensive health insurance bill in the next Congress or adopt a position of hard-line opposition? That question will be answered in the coming months. In light of recent events the ISMS policy of opposition to "federally mandated compulsory national health insurance" seems more reasonable than ever.

David S. Fox, M.D., President

# Doctor's News

**PESTICIDE POISONING INFORMATION**—The U.S. Environmental Protection Agency has asked that Illinois physicians become aware of an available pesticide poisoning information service. Poison Control Centers provide immediate information for diagnosis and treatment of patients overexposed to hazardous chemicals. For information during emergencies telephone (312) 353-2192 between 8 a.m. and 4:30 p.m. during the week or mail inquiries to: Chief, Pesticide Branch, U.S. Environmental Protection Agency, 230 South Dearborn Street, Chicago, Illinois 60604.

An additional source of data about pesticide overexposure is the U.S. Environmental Protection Agency's Pesticide Branch in Chicago. Pesticide safety publications are available from the Branch including a 75 page medical treatment manual entitled "Recognition and Management of Pesticide Poisonings." This manual is composed of a chapter on each major chemical classification of pesticides. Each contains a brief section containing: 1) names of the most commonly used pesticides belonging to the group; 2) toxicology; 3) frequent signs and symptoms of overexposure, and 4) recommended treatment.

**PHYSICIANS URGED TO BILL MEDICAID AT USUAL RATE**—Physicians billing IDPA for Medicaid services are advised to submit vouchers for usual, customary and reasonable charges. A physician billing for what is expected from IDPA rather than normal fees would create a false fee profile with the Dept. . . . and reimbursement levels actually could be lowered when the schedules are updated. Recent changes involving other government health programs are:

- IDPA has granted a $2 increase in physician reimbursement for Medichek office visits. Reimbursement now will be set at the $8 level. The Dept. will return bills submitted under the previous $6 rate for resubmission at the new level—provided services were rendered after July 1.
- Questions or complaints involving the CHAMPUS program should be directed to the ISMS Field Services staff. ISMS and the Wisconsin Physicians Service—the CHAMPUS fiscal intermediary—recently signed an agreement for the Society to assist physicians with billing problems, provide peer review and conduct facilities review.

**ISIM ANNUAL MEETING**—Dr. Donald H. Hanscom, president, Illinois Society of Internal Medicine (ISIM), recently announced the Society's Annual Meeting will be held October 20-21, 1978, Ramada Convention Center, Champaign, Illinois. The October 20 banquet will feature Edward J. Stemmler, M.D., on the topic, "A New Era in Medical Education." At a special October 21 presentation, Christopher Cohen, principal regional official, HEW Region V; Jess Diamond, M.D., president, Foundation for Medical Care of Central Illinois; and David Hyland, executive director, Quad River Foundation for Medical Care, will discuss federal and state agencies and their effects on Illinois internists.

The ISIM meeting is being held in conjunction with the Illinois Chapter, American College of Physicians. For additional information, please call Jean E. Althoff, ISIM, 55 East Monroe, Suite 3510, Chicago 60603. (312) 782-1654.

**DANGEROUS DRUGS COMMISSION TAKES ACTION ON PENTAZOCINE**—At an August 1 meeting, the Illinois DDC voted unanimously to place Talwin (generic term: Pentazocine) on Schedule II of the Illinois Controlled Substances Act. Schedule II imposes the most stringent restrictions on prescribing, limits availability, and eliminates telephone prescribing in all but emergencies. The DDC will consider designated product category (triplicate prescription form) at its October meeting.

**PHYSICIANS IN THE NEWS**—**Donald A. Rowley, M.D.**, has been appointed director of the LaRabida Children's Hospital and Research Center in Chicago. Director of research at the center since 1973, Doctor Rowley is a former associate editor of the Journal of Immunology. . . . **Alvin R. Tarlov, M.D.**, Chicago, has been named chairman of the HEW Graduate Medical Education National Advisory Committee. Doctor Tarlov is chairman of the department of medicine in the Division of Biological Sciences and Pritzker School of Medicine at the University of Chicago. . . . Illinois Masonic Medical Center recently announced that **Edwin Feldman, M.D.**, Chicago, has been appointed to serve as medical director. Doctor Feldman, an associate professor of clinical medicine at the University of Illinois, is currently chairman of their department of internal medicine. . . . **W. L. Crawford, M.D.**, Rockford, has been presented the Forward Rockford Award by the Rockford Area Chamber of Commerce. The award noted Doctor Crawford's contributions to the quality of life in the Rockford Community, noting particularly the founding of Rockford Memorial Hospital and School of Medicine and the Winnebago County Medical Society Library.

**LCCME HOLDS WORKSHOP**—The Liaison Committee on Continuing Medical Education, the national accrediting body in CME, held a workshop for their subcommittee on goals and priorities on August 30, at the Marriott O'Hare. Clement Brown, Jr., M.D., director of medical education for South Chicago Community Hospital, Donald Pochley, M.D., M.Ed., provost and acting president, Univ. of Health Sciences/The Chicago Medical School, and Leonard Stein, Ph.D., executive director, Illinois Council on Continuing Medical Education, served on a panel for the program. The workshop was chaired by William Mayer, M.D., Veterans Administration Chief Academic Officer. It was designed to establish revised plans for accreditation in terms of goals and objectives, methods and personal learning plans.

**JCAH STANDARDS**—The Joint Commission on Accreditation of Hospitals "Revised Standards for Medical Staffs," became effective February 1, 1978. The standards include several provisions of concern to physicians. While the former standards set few specific requirements for hospital staff membership beyond licensure and application, the new standards make further credential requirements. Hospital privileges are also further defined, beyond the former specialty indices. For the first time, a physician's individual health will be considered in reappointment evaluations. Individual staff responsibilities are now to be clearly delineated in the hospital bylaws. Other provisions regarding bylaws have also been clarified, particularly those regarding appeal mechanisms in appointment denials and suspension, curtailment or revocation of privileges. Regular patient care evaluations through utilization review, audits, etc., will include quality controls at many levels. A last important change involves specified requirements for hospital-sponsored CME programs. These now must occur at least quarterly in every hospital, although they may be incorporated into medical staff meetings.

# IMPAC

**ILLINOIS MEDICAL POLITICAL ACTION COMMITTEE**
55 East Monroe Street
Chicago, Illinois 60603
312/782-1963



YOU'VE COME A LONG WAY

BUT



There's still a long way to go. Physicians' spouses made up less than one per cent of IMPAC's membership when we first started. Now, one out of two people who belong to IMPAC is a physician's spouse. IMPAC leads the nation in spouse membership. Help us continue our tradition of leadership. Join IMPAC in 1978...and bring a friend.

---

**IMPAC/AMPAC Membership**
(check one)

☐ Sustaining, $99 ☐ Family, $45 ☐ Regular, $25 ☐ Auxiliary, $20

Return to:
IMPAC, 55 E. Monroe Street, Suite 3510, Chicago, Illinois 60630

**NAME** _____ **PHONE** _____

**ADDRESS** _____ **CITY** _____ **ZIP** _____

Contributions are not limited to the suggested amount. Neither the Illinois State Medical Society nor the AMA will favor or disadvantage anyone based upon the amounts of or failure to make pac contributions. Copies of IMPAC & AMPAC reports are filed with and are available for purchase from the Federal Election Commission, Washington, D.C. Contributions are subject to the limitations of FEC regulations, Sections 110.1, 110.2 & 110.5. (Federal regulations require this notice.) IMPAC reports are also filed with the State Board of Elections, and are or will be available for purchase from the State Board of Elections, 1020 South Spring Street, Springfield, Illinois 62704.

NONPARTISAN

# ISMS Guide to Continuing Medical Education

Compiled for Illinois physicians by the
ILLINOIS COUNCIL ON CONTINUING MEDICAL EDUCATION
55 E. Monroe St., Suite 3510 • Chicago, IL 60603 • (312) 236-6110

*Items for this Calendar must be received 90 days prior to the event. Those received earlier may appear in up to three monthly issues.*

*WARNING! Items for this Calendar come from many sources, often far in advance of the publication date. Sometimes, cancellations or changes in date, place or time occur too late to be corrected before publication. You are urged to contact the sponsoring organization to confirm information given below.*

## OCTOBER

### *Allergy*

**IMMUNOLOGIC INJURY**
**For:** Family Practitioners, Allergists. Lecture, Oct. 18, 2:00 p.m., Itasca Country Club. **Speaker:** Chester R. Zeiss Jr., M.D., Asst. Professor of Medicine, Northwestern University Medical School. **Sponsor:** DuPage County Medical Society, 26 W. St. Charles Road, Lombard, IL 60148. **Reg. deadline:** 10/16. **Fee:** none. **Reg. limit:** none. **CME Credit:** AAFP Elective, 2 hours; AMA Category 1, 2 hours. **Contact:** Lillian Widmer. **Phone:** 312-495-4050.

### *Biomed*

**FOURTH ANNUAL MEDICAL PHOTOGRAPHY WORKSHOP**
**For:** all physicians. 1-day symposium/workshop, October 28, Springfield, IL. **Sponsor:** SIU School of Medicine, P.O. Box 3926, Springfield, IL 62708. **CME Credit:** AAFP Elective, 6 hours; AMA Category 1, 6 hours. **Reg. limit:** none. **Contact:** Lorraine Stephenson. **Phone:** 217-782-7711.

### *Diabetes*

**RECENT ADVANCES IN DIABETES**
**For:** residents and attending staff. Lecture, October 25, 11:00 a.m. (lunch follows), Martha Washington Hospital, 4055 N. Western, Chicago, IL 60618. **Speaker:** Arthur H. Rubenstein, M.D., Professor and Associate Chairman, Dept. of Medicine, The University of Chicago. **CME Credit:** AAFP Elective, 1 hour; AMA Category 1, 1 hour. **Fee:** none. **Reg. limit:** none. **Reg. deadline:** 10/24. **Sponsor:** Martha Washington Hospital. **Contact:** Fernando Villa, M.D. **Phone:** 312-583-9000 x 331.

### *Endocrinology*

**CLINICAL ENDOCRINOLOGY FOR 1978**
**For:** General Practitioners. Lecture, Oct. 25, 1:30-5:20 p.m., Chicago. **Sponsor:** The University of Chicago Medical Center, Frontiers of Medicine, 950 E. 59th St., Box 451, Chicago, IL 60637. **CME Credit:** AAFP Elective, 3 hours; AMA Category 1, 3 hours. **Fee:** $20. **Reg. limit:** none. **Contact:** Elaine Ehrman. **Phone:** 312-947-5777.

### *Family Medicine—Psychiatry*

**MIDWEST SYMPOSIUM ON AFFECTIVE DISORDERS/DEPRESSION UPDATE: DIAGNOSIS AND MANAGEMENT IN EVERYDAY PRACTICE**
**For:** Psychologists, Psychiatrists, General and Family Practitioners. Symposium, Oct. 5-6, 9:00-4:30 p.m., Holiday Inn-Chicago City Centre, Chicago. **Sponsor:** Abraham Lincoln School of Medicine, Dept. of Psychiatry, 1853 W. Polk St., Room 144, Chicago, IL 60612. **Reg. deadline:** 9/20. **Fee:** $135. **Reg. limit:** 200. **CME Credit:** AMA Category 1, 12 hours. **Contact:** Sue Korienek. **Phone:** 312-996-8025.

### *Internal Medicine, Family Practice, Pediatrics*

**CLINICAL ALLERGY FOR PRACTICING PHYSICIANS**
**For:** Physicians. 3-day symposium, October 5-7, St. Louis, MO. **Sponsor:** Continuing Medical Education, Washington University School of Medicine, Box 8063, 660 S. Euclid, St. Louis, MO 63110. **CME Credit:** AAFP Elective, 16 hours; AMA Category 1, 16 hours; AOA, 16 hours. **Fee:** $150. **Reg. limit:** 150. **Contact:** Loretta Giacoletto. **Phone:** 314-454-3873.

### *Internal Medicine*

**CLINICAL & LABORATORY DIAGNOSIS OF HEMORRHAGIC & THROMBOTIC DISORDERS**
**For:** Internists, Hematologists. Lecture, beginning Oct. 20, Chicago. **Speaker:** Hau C. Kwaan, M.D. **Sponsor:** Cook County Graduate School of Medicine, 707 South Wood St., Chicago 60612. **Fee:** $150. **Reg. limit:** none. **CME Credit:** AMA Category 1, 16 hours. **Contact:** Robert Baker, M.D. **Phone:** 312-733-2800.

### *Medical Photography*

**FOURTH ANNUAL MEDICAL PHOTOGRAPHY WORKSHOP**
**For:** M.D.'s, office staff. 1-day workshop, Oct. 28, Springfield, IL. **Sponsor:** SIU School of Medicine, 801 N. Rutledge, P.O. Box 3926, Springfield, IL. **Fee:** $55-pre. **Reg. limit:** none. **CME Credit:** AMA Category 1, 6 hours. **Contact:** Lorraine Stephenson. **Phone:** 217-782-7711.

### *Medicine*

**GENERAL MEDICINE LECTURE SERIES**
**For:** M.D.'s. Lecture series, Oct. 3 thru Dec. 26, 11:00-12:30 p.m, Chicago. **Sponsor:** St. Mary of Nazareth Hospital Center, 2233 W. Division St., Chicago, IL 60622. **Fee:** none. **Reg. limit:** 75. **CME Credit:** AAFP Elective, 1½ hours; AMA Category 1, 1½ hours. **Contact:** Anthony Sapienza, M.D. **Phone:** 312-770-2060.

### *Medicine and Surgery*

**MEDICAL AND SURGICAL APPROACHES TO ACUTE COLON AND RECTAL DISEASES**
**For:** Physicians. Symposium, October 26, Hillsboro, IL. **Sponsor:** SIU School of Medicine, P.O. Box 3926, Springfield, IL 62708. **CME Credit:** AAFP Elective, 4 hours; AMA Category 1, 4 hours. **Reg. limit:** none. **Contact:** Lorraine Stephenson. **Phone:** 217-782-7711.

### *Neurology*

**SYMPOSIUM ON NEUROMUSCULAR DISEASE**
**For:** Neurologists, Psychiatrists, Pathologists. Symposium, Oct. 26-27, 8:30-4:00 p.m., North Chicago, IL. **Sponsor:** Neurology Service, North Chicago VAH & Dept. Neurology, UHS/The Chicago Medical School, Dept. Neurology, Bldg. 50, Suite 233, VA Hospital, North Chicago, IL 60064. **Reg. deadline:** 10/1. **Fee:** none. **Reg. limit:** 50. **CME Credit:** AMA Category 1, 12 hours. **Contact:** Charles Morris, M.D. **Phone:** 312-473-9200 x 261.

### *Neurology*

**NEUROLOGY UPDATE**
**For:** Physicians. Symposium, October 7, Pittsfield, IL. **Sponsor:** SIU School of Medicine, P.O. Box 3926, Springfield, IL 62708. **CME Credit:** AAFP Elective, 4 hours; AMA Category 1, 4 hours. **Reg. limit:** none. **Contact:** Lorraine Stephenson. **Phone:** 217-782-7711.

### *Neurotology*

**CLINICAL NEUROTOLOGY**
**For:** Otologists, Neurotologists. 4-day course, October 16-19, Chicago, IL. **Speaker:** Nicholas Torok, M.D. **Sponsor:** Dept. of Otolaryngology, ALS.M., Illinois Eye & Ear Infirmary, Neurotology Section, 1855 W. Taylor, Chicago, IL 60612. **Cosponsor:** American Neurotology Society. **CME Credit:** AMA Category 1, 28 hours. **Fee:** $300. **Contact:** Nicholas Torok, M.D. **Phone:** 312-996-6517.

### *Obstetrics & Gynecology*

**RECERTIFICATION REVIEW IN OB-GYN**
**For:** Obstetricians, Gynecologists. Lecture, beginning Oct. 30, Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 South Wood St., Chicago 60612. **Fee:** $225. **Reg. limit:** none. **CME Credit:** AMA Category 1, 40 hours. **Contact:** Robert Baker, M.D. **Phone:** 312-733-2800.

### *Orthopaedics*

**MANAGEMENT OF COMMON FRACTURES**
**For:** Family Practitioners. Lecture, beginning Oct. 23, Chicago. **Speaker:** Peter Altner, M.D. **Sponsor:** Cook County Graduate School of Medicine, 707 South Wood St., Chicago 60612. **Fee:** $225. **Reg. limit:** 50. **CME Credit:** AAFP Prescribed, 35 hours; AMA Category 1, 35 hours. **Contact:** Robert Baker, M.D. **Phone:** 312-733-2800.

### *Psychiat*

**DISTINGUISHED LECTURE SERIES**
**For:** Psychiatrists, mental health professionals. ture, Oct. 18, 8:00 p.m., Offield Auditorium, P savant Pavilion, 303 E. Superior, Chicago. **Speak** Daniel Offer, M.D., Professor of Psychiatry, U of **Sponsor:** Institute of Psychiatry, Northwestern I morial Hospital and Dept. of Psychiatry and havioral Sciences, NUMS. **Reg. limit:** none. **C Credit:** AMA Category 1, 1½ hours. **Fee:** no **Contact:** Leon Diamond. **Phone:** 312-649-8058.

**GENERAL PSYCHIATRY STUDY GROUP**
**For:** Psychiatrists. study group, 1st Sat. of mo., 9 a.m.-12:00 noon, Institute of Psychiatry, 320 Huron, Rm. 2011, Chicago. **Sponsor:** Institute Psychiatry, Northwestern Memorial Hospital and De of Psychiatry and Behavioral Sciences, NUMS. R **limit:** 20. **Fee:** $150. **CME Credit:** AMA Category 24 hours. **Reg. deadline:** 9/30. **Contact:** Leon D mond. **Phone:** 312-649-8058.

**PSYCHOANALYTIC STUDY GROUP**
**For:** Psychiatrists. Study group, 3rd Sat. of 9:00 a.m.-12:00 noon, Institute of Psychiatry, 3 E. Huron, Rm. 2011, Chicago. **Sponsor:** Institute Psychiatry, Northwestern Memorial Hospital and De of Psychiatry and Behavioral Sciences, NUMS. R **limit:** 20. **Fee:** $150. **CME Credit:** AMA Category 24 hours. **Reg. deadline:** 9/30. **Contact:** Leon D mond. **Phone:** 312-649-8058.

**RECENT ADVANCES IN PSYCHIATRY**
**For:** Psychiatrists. Lecture, beginning Oct. 23, C cago. **Speaker:** Domeena Renshaw, M.D. **Spons** Cook County Graduate School of Medicine, 707 So Wood St., Chicago 60612. **Fee:** $225. **Reg. lim** 125. **CME Credit:** AMA Category 1, 40 hours. C **tact:** Robert Baker, M.D. **Phone:** 312-733-2800.

**ILLINOIS PSYCHIATRIC SOCIETY 5th ANNUAL F WEEKEND MEETING**
**For:** Psychiatrists, other physicians. 3-day lectu workshop, October 6-8, Hyatt Regency O'Hare, C cago, IL. **Sponsor:** Illinois Psychiatric Society, 55 Monroe, Suite 3510, Chicago, IL 60603. **CME Cre** AMA Category 1, 13.5 hours. **Fee:** $35. **Reg. lim** none. **Reg. deadline:** 9/25. **Contact:** Wendy Sm **Phone:** 312-782-1654.

### *Radiolo*

**DIAGNOSTIC IMAGING OF THE GASTROINTESTINA TRACT**
**For:** Radiologists. 4-day course, Oct. 12-15, Lake the Ozarks, MO. **Sponsor:** American College of Ra ology. **Fee:** $225. **CME Credit:** AMA Category 1, hours. **Contact:** Walter Whitehouse, M.D., Dept. Rad., U of Michigan Hospital, Ann Arbor, Michi 48109.

### *Surge*

**SPECIALTY REVIEW IN GENERAL SURGERY, PAR** **For:** Surgeons. Lecture, beginning Oct. 23, Chica **Speaker:** Robert Baker, M.D. **Sponsor:** Cook Cou Graduate School of Medicine, 707 South Wood S Chicago 60612. **Fee:** $425. **Reg. limit:** 400. **C Credit:** AMA Category 1, 94 hours. **Contact:** Rob Baker, M.D. **Phone:** 312-733-2800.

### *Surge*

**CLINICAL CONGRESS**
**For:** Physicians. 5-day lecture, October 16-20, Francisco, CA. **Sponsor:** American College of S geons, 55 E. Erie, Chicago, IL 60611. **CME Cre** AMA Category 1. **Contact:** Ginny Clark. **Phone:** 3 664-4050.

# NOVEMBER

## Anesthesia

**REGIONAL ANESTHESIA**
**For:** Anesthesiologists. Lecture, beginning Nov. 13, Chicago. **Speakers:** Vincent Collins, M.D. **Sponsor:** Cook County Graduate School of Medicine, 707 South Wood St., Chicago 60612. **Fee:** $325. **Reg. limit:** 10. **CME Credit:** AMA Category 1, 40 hours. **Contact:** Robert Baker, M.D. **Phone:** 312-733-2800.

## Diabetes

**NEW HORIZONS—1979**
**For:** M.D.'s, allied health professionals. Symposium, Nov. 29, 9:00-4:00 p.m., The Drake Hotel, Chicago. **Sponsor:** American Diabetes Association, Northern Illinois Affiliate, 620 No. Michigan Ave., Chicago, IL 60611. **Reg. deadline:** 11/24. **Fee:** $20/$15. **Contact:** Florence Narodick. **Phone:** 312-943-8668.

## Emergency Medicine

**ENVIRONMENTAL EMERGENCIES AND MASS CASUALTY DISASTERS**
**For:** General Practitioners. Lecture, Nov. 8, 9:30-4:40 p.m., Chicago, IL. **Sponsor:** The University of Chicago Medical Center, Frontiers of Medicine, 950 E. 59th St., Box 451, Chicago, IL 60637. **Fee:** $30. **Reg. limit:** none. **CME Credit:** AAFP Elective, 6 hours; AMA Category 1, 6 hours. **Contact:** Elaine Ehrman. **Phone:** 312-947-5777.

## Family Medicine

**MANAGEMENT OF THE ACUTE CARDIAC PATIENT**
**For:** Family Practitioners. Lecture, beginning Nov. 29, Chicago. **Speaker:** Kenneth Rosen, M.D. **Sponsor:** Cook County Graduate School of Medicine, 707 South Wood St., Chicago 60612. **Fee:** $175. **Reg. limit:** 75. **CME Credit:** AMA Category 1, 21 hours. **Contact:** Robert Baker, M.D. **Phone:** 312-733-2800.

## Internal Medicine—Allergy

**IMMUNOLOGICAL ASPECTS OF RESPIRATORY TRACT DISEASE**
**For:** M.D.'s, residents. Lecture, Nov. 8, Chicago. **Sponsor:** Martha Washington Hospital, 4055 No. Western Ave., Chicago, IL 60618. **Reg. deadline:** none. **Reg. limit:** none. **Fee:** none. **CME Credit:** AAFP, 1 hour; AMA Category 1, 1 hour. **Contact:** Fernando Villa, M.D. **Phone:** 312-583-9000 x 331.

## Internal Medicine

**RESPIRATORY DISEASE**
**For:** M.D.'s. Symposium, Nov. 30, Jacksonville, IL **Sponsor:** SIU School of Medicine, P.O. Box 3926, Springfield, IL 62708. **Reg. limit:** none. **CME Credit:** AAFP Elective, 4 hours; AMA Category 1, 4 hours. **Contact:** Lorraine Stephenson. **Phone:** 217-782-7711.

**CHRONIC OBSTRUCTIVE PULMONARY DISEASE**
**For:** M.O.'s. Symposium, Nov. 8, Harrisburg, IL. **Sponsor:** SIU School of Medicine, P.O. Box 3926, Springfield, IL 62708. **Reg. limit:** none. **CME Credit:** AMA Category, 1, 4 hours; AAFP Elective. 4 hours. **Contact:** Lorraine Stephenson. **Phone:** 217-782-7711.

**BLOOD GASES-ELECTROLYTE IMBALANCE-HYPERALIMENTATION**
**For:** M.D.'s. Symposium, Nov. 4, Highland, IL. **Sponsor:** SIU School of Medicine, P.O. Box 3926, Springfield, IL 62708. **Reg. limit:** none. **CME Credit:** AMA Category 1, 4 hours; AAFP Elective, 4 hours. **Contact:** Lorraine Stephenson. **Phone:** 217-782-7711.

**6TH ANNUAL WEBER MEDICAL CLINIC**
**For:** M.D.'s. Clinic, Nov. 4, Olney, IL. **Sponsor:** SIU School of Medicine, P.O. Box 3926, Springfield, IL 62708. **Reg. limit:** none. **CME Credit:** AMA Category 1, 4 hours; AAFP Elective, 4 hours. **Contact:** Lorraine Stephenson. **Phone:** 217-782-7711.

### CME VIDEO CLINICS

AMA now has available a number of video clinic "packages" consisting of a videotape, syllabus and test. Clinics meet criteria for Category 1 credit toward the Physician's Recognition Award. For information on programs available, costs, etc., contact: AMA Division on Continuing Medical Studies, 535 North Dearborn Street, Chicago, Illinois 60610.

## Internal Medicine, Family Medicine

**EMERGENCY CARDIOLOGY—DIAGNOSIS AND THERAPY**
**For:** M.D.'s. Symposium, Nov. 30-Dec. 1, St. Louis, MO. **Sponsor:** Continuing Medical Education, Washington University School of Medicine, Box 8063, 660 S. Euclid, St. Louis, MO 63110. **Fee:** $120. **Reg. limit:** 150. **CME Credit:** AMA Category 1, 12 hours; AAFP Elective, 12 hours. **Contact:** Loretta Giacoletto. **Phone:** 314-454-3873.

## Medicine

**ADVANCES IN MEDICINE**
**For:** Internists. Lecture, beginning Nov. 13, Chicago. **Speaker:** Sheldon Waldstein, M.D. **Sponsor:** Cook County Graduate School of Medicine, 707 South Wood St., Chicago 60612. **Fee:** $225. **Reg. limit:** 100. **CME Credit:** AMA Category 1, 35 hours. **Contact:** Robert Baker, M.D. **Phone:** 312-733-2800.

## Neurology

**RECENT ADVANCES IN NEUROLOGY**
**For:** Neurologists. Lecture, beginning Nov. 13, Chicago. **Speaker:** Neil Allen, M.O. **Sponsor:** Cook County Graduate School of Medicine, 707 South Wood St., Chicago 60612. **Fee:** $225. **Reg. limit:** 75. **CME Credit:** AMA Category 1, 40 hours. **Contact:** Robert Baker, M.D. **Phone:** 312-733-2800.

## Obstetrics & Gynecology

**ADVANCES IN OBSTETRICS & GYNECOLOGY**
**For:** Obstetricians, Gynecologists. Lecture, beginning Nov. 30, Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 South Wood St., Chicago 60612. **Fee:** $175. **Reg. limit:** 100. **CME Credit:** AMA Category 1, 24 hours. **Contact:** Robert Baker, M.D. **Phone:** 312-733-2800.

**OB/GYN IN GENERAL PRACTICE**
**For:** M.D.'s. Symposium, Nov. 16, Mt. Vernon, IL. **Sponsor:** SIU School of Medicine, P.O. Box 3926, Springfield, IL 62708. **Reg. limit:** none. **CME Credit:** AMA Category 1, 4 hours; AAFP Elective, 4 hours. **Contact:** Lorraine Stephenson. **Phone:** 217-782-7711.

**MANAGEMENT OF HIGH RISK OBSTETRICAL & NEWBORN PROBLEMS**
**For:** Obstetricians, Pediatricians. Lecture, beginning Nov. 13, Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 South Wood St., Chicago 60612. **Fee:** $250. **Reg. limit:** 100. **CME Credit:** AMA Category 1, 50 hours. **Contact:** Robert Baker, M.D. **Phone:** 312-733-2800.

## Ophthalmology

**CLINICAL UPDATE IN GLAUCOMA AND CORNEAL AND EXTERNAL DISEASE**
**For:** Ophthalmologists. Lecture, Nov. 9-10, Chicago. **Sponsor:** Dept. of Ophthalmology, U of I, 1855 W. Taylor, Chicago 60612. **Fee:** $150. **Reg. limit:** 60. **CME Credit:** AMA Category 1. **Contact:** Carmen Carrasco. **Phone:** 312-996-8023.

## Orthopedics

**RHEUMATOLOGY AND JOINT RECONSTRUCTION**
**For:** M.D.'s. Symposium, Nov. 9, Quincy, IL. **Sponsor:** SIU School of Medicine, P.O. Box 3926, Springfield, IL 62708. **Reg. limit:** none. **CME Credit:** AMA Category 1, 4 hours; AAFP Elective, 4 hours. **Contact:** Lorraine Stephenson. **Phone:** 217-782-7711.

**SPINAL PROBLEMS**
**For:** M.O.'s. Symposium, Nov. 15, Belleville, IL. **Sponsor:** SIU School of Medicine, P.O. Box 3926, Springfield, IL 62708. **Reg. limit:** none. **CME Credit:** AMA Category 1, 4 hours; AAFP Elective, 4 hours. **Contact:** Lorraine Stephenson. **Phone:** 217-782-7711.

## Psychiatry

**DIAGNOSIS & MANAGEMENT OF EMOTIONAL PROBLEMS IN CHILDREN & ADULTS**
**For:** Family Practitioners. Lecture, beginning Nov. 20, Chicago. **Speaker:** Domeena Renshaw, M.D. **Sponsor:** Cook County Graduate School of Medicine, 707 South Wood St., Chicago, 60612. **Fee:** $150. **Reg. limit:** 100. **CME Credit:** AAFP Prescribed, 17 hours; AMA Category 1, 17 hours. **Contact:** Robert Baker, M.D. **Phone:** 312-733-2800.

## Surgery

**SPECIALTY REVIEW IN SURGERY, PART II**
**For:** Surgeons. Lecture, beginning Nov. 27, Chicago. **Speaker:** Robert Baker, M.D. **Sponsor:** Cook County Graduate School of Medicine, 707 South Wood St., Chicago 60612. **Fee:** $425. **Reg. limit:** 300. **CME Credit:** AMA Category 1, 99 hours. **Contact:** Robert Baker, M.D. **Phone:** 312-733-2800.

## Urology

**104TH ANNUAL MEETING OF SOUTHERN ILLINOIS MEDICAL ASSOCIATION**
**For:** M.D.'s. Lecture, Nov. 9, Village of Muddy, IL. **Sponsor:** Southern Illinois Medical Association. **Co-sponsor:** Illinois Academy of Family Physicians. **Reg. deadline:** none. **Fee:** none. **Reg. limit:** none. **CME Credit:** AMA Category 1, 4 hours. **Contact:** Dale Rosenberg, M.D., Suite 3-E, 6401 W. Main St., Belleville, IL. **Phone:** 618-398-5600.

# DECEMBER

## Internal Medicine

**JAUNDICE**
**For:** M.D.'s. Symposium, Dec. 7, DuQuoin, IL. **Sponsor:** SIU School of Medicine, P.O. Box 3926, Springfield, IL 62708. **Reg. limit:** none. **CME Credit:** AAFP Elective, 4 hours; AMA Category 1, 4 hours. **Contact:** Lorraine Stephenson. **Phone:** 217-782-7111.

## Psychiatry

**OFFICE PSYCHIATRY**
**For:** M.D.'s. Symposium, Dec. 14, Effingham, IL. **Sponsor:** SIU School of Medicine, P.O. Box 3926, Springfield, IL 62708. **Reg. limit:** none. **CME Credit:** AAFP Elective, 3 hours; AMA Category 1, 3 hours. **Contact:** Lorraine Stephenson. **Phone:** 217-782-7711.

## Nephrology

**FLUID AND ELECTROLYTE BALANCE, HYPERTENSION AND RENAL DISEASE**
**For:** Internists, General Practitioners. Course/workshops, Dec. 4-8, Chicago, IL. **Sponsor:** American College of Physicians, 4200 Pine St., Philadelphia, PA 19104. **Cosponsor:** Northwestern University Medical School, Northwestern Memorial Hospital. **Reg. limit:** 160. **Fee:** ACP member, FACP, residents, $327; nonmember, $436; ACP Assoc., $163. **CME Credit:** AMA Category 1, 30 hours. **Contact:** Linda Salsinger. **Phone:** 215-243-1200.

## Surgery

**For:** General Practitioners. Lecture, Dec. 6, 2:00-4:40 p.m., Chicago. **Sponsor:** The University Chicago Medical School, Frontiers of Medicine, 950 E. 59th St., Box 451, Chicago, IL 60637. **Fee:** $20. **Reg. limit:** none. **CME Credit:** AAFP Elective, 3 hours; AMA Category 1, 3 hours. **Contact:** Elaine Ehrman. **Phone:** 312-947-5777.

### MEDICINE FOR TODAY
*Fall Sessions*

***For:*** **Family Practitioners (emphasis on Cardiology, Gynecology, Endrocrinology, Pulmonary). 30th Annual Postgraduate Program of the Illinois Academy of Family Physicians. *CME Credit:* AMA Category 1, 30 hours; AAFP Prescribed, 30 hours. *Fee:* $100, members; $110, non-members. Schedule includes:**

***Belleville*—Oct. 19, 26; Nov. 2, 9, 16, 30**
***Berwyn*—Oct. 18, 25; Nov. 1, 8, 15, 29**
***Beverly*—Oct. 18, 25; Nov. 1, 8, 15, 29**
***Centralia*—Oct. 18; Nov. 1, 15**
***Champaign*—Oct. 26; Nov. 9, 30**
***Chicago Nearwest*—Oct. 18, 25; Nov. 1, 8, 15, 29**
***Chicago North*—Oct. 18, 25; Nov. 1, 8, 15, 29**
***Chicago Southwest*—Oct. 18, 25; Nov. 1, 8, 15, 29**
***Harvey*—Oct. 18, 25; Nov. 1, 8, 15, 29**
***Hinsdale*—Oct. 18; Nov. 1, 15**
***Melrose Park*—Oct. 18, 25; Nov. 1, 8, 15, 29**
***Park Ridge*—Oct. 18, 25; Nov. 1, 8, 15, 29**
***Peoria*—Oct. 19; Nov. 2, 16**
***Rockford*—Oct. 26; Nov. 9, 30**
***Rock Island*—Oct. 26; Nov. 9, 30**
***Springfield*—Oct. 19; Nov. 9**

**For complete information, contact: Illinois Academy of Family Physicians, 1200 Harger Road, Suite 405, Oak Brook, Illinois 60521. Phone: 312-325-8502.**




# The Allied Health Committee of the American Cancer Society, Illinois Division

Ruby Jackson, CMA/Chicago

Rapid expansion of health care team and multi-disciplinary approaches to health care has given Illinois Society the opportunity to be included in the American Cancer Society, Illinois Division's plan to develop an Allied Health Committee. Representatives of social workers, radiologic technologists, dieticians, medical technologists, clergy, cytotechnologists, occupational therapists and physical therapists have also been invited to participate.

Chaplain Willis C. Graves of Hinsdale Hospital is the chairman. He is assisted by Dr. John Morrison, University of Illinois and Mrs. Kathy Ling, Director of Professional Education, American Cancer Society, Illinois Division.

The objectives of the program are to: (1) See the cancer patient as an individual with medical, social and spiritual needs; (2) Identify and foster appropriate roles of allied health professionals in cancer control efforts including public education geared to prevention and detection; and (3) Promote awareness of allied health's role within the spectrum of health care providers, the multi-disciplinary health care team approach and the public.

A tentative program for educators has been planned for the fall of 1978. This one day seminar would encompass detection, rehabilitation and prevention of cancer as related to each medical specialty.

It is hoped that if this seminar is successful the program can be used as the basis for a clinical conference open to all medical assistants and health care professionals. Such a program would be designed for the working health professional. Knowledge regarding particular types of cancer as well as how the patient is cared for in various areas of the health care delivery system would be emphasized.

It is important to know the physical and psychological effects seen in patient and family during treatment stages. Allied health professionals contribute much to the diagnosis, treatment and prognosis of the cancer patient and must also see to their comfort using all available resources. Reach to Recovery, Easter Seal Society, prosthetic device providers and others would be asked to participate at this meeting.

If you are interested in a seminar of the dimensions as specified above, please send a postcard to Mrs. Leslie Lee, President, Illinois Society, American Association of Medical Assistants, c/o Vladimir & Neda Z. Tkalcevic, M.D., 467 Deming Place, Suite 901, Chicago, IL 60614.




# Does it influence your choice of a peripheral/cerebral vasodilator*?

- Vasodilan—compatible with coexisting diseases
- Vasodilan—compatible with concomitant therapy
- Vasodilan—compatible with your total regimen for vascular insufficiency

*Indications: Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows:

Possibly Effective:

1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.

Final classification of the less-than-effective indications requires further investigation.

**Composition:** Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg.
Vasodilan injection, isoxsuprine HCl, 5 mg., per ml.

**Dosage and Administration:** Oral: 10 to 20 mg., three or four times daily.
Intramuscular: 5 to 10 mg. (1 or 2 ml.) two or three times daily. Intramuscular administration may be used initially in severe or acute conditions.

**Contraindications and Cautions:** There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

Parenteral administration is not recommended in the presence of hypotension or tachycardia.

Intravenous administration should not be given because of increased likelihood of side effects.

**Adverse Reactions:** On rare occasions oral administration of the drug has been associated in time with the occurrence of hypotension, tachycardia, nausea, vomiting, dizziness, abdominal distress, and severe rash. If rash appears the drug should be discontinued.

Although available evidence suggests a temporal association of these reactions with isoxsuprine, a causal relationship can be neither confirmed nor refuted.

Administration of single dose of 10 mg. intramuscularly may result in hypotension and tachycardia. These symptoms are more pronounced in higher doses. For these reasons single intramuscular doses exceeding 10 mg. are not recommended. Repeated administration of 5 to 10 mg. intramuscularly at suitable intervals may be employed.

**Supplied:** Tablets, 10 mg., bottles of 100, 1000, 5000 and Unit Dose; Tablets, 20 mg., bottles of 100, 500, 1000, 5000 and Unit Dose; Injection, 10 mg. per 2 ml. ampul, box of six 2 ml. ampuls.

U.S. Pat. No. 3,056,836

# VASODILAN®
## (ISOXSUPRINE HCl)
**20-mg tablets**

Mead Johnson PHARMACEUTICAL DIVISION

# This asthmatic isn't worried about his next breath...



## he's active
## he's effectively maintained on

# QUIBRON®

Each capsule or tablespoon (15 ml) elixir contains theophylline (anhydrous) 150 mg and glyceryl guaiacolate (guaifenesin) 90 mg. Elixir: alcohol 15%

- theophylline for effective around-the-clock bronchodilator therapy
- 100% free theophylline

**Indications:** For the symptomatic relief of bronchospastic conditions such as bronchial asthma, chronic bronchitis, and pulmonary emphysema.

**Warnings:** Do not administer more frequently than every 6 hours, or within 12 hours after rectal dose of any preparation containing theophylline or aminophylline. Do not give other compounds containing xanthine derivatives concurrently.

**Precautions:** Use with caution in patients with cardiac disease, hepatic or renal impairment. Concurrent administration with certain antibiotics, i.e. clindamycin, erythromycin, troleandomycin, may result in higher serum levels of theophylline. Plasma prothrombin and factor V may increase, but any clinical effect is likely to be small. Metabolites of guaifenesin may contribute to increased urinary 5-hydroxyindoleacetic acid readings, when determined with nitrosonaphthol reagent. Safe use in pregnancy has not been established. Use in case of pregnancy only when clearly needed.

**Adverse Reactions:** Theophylline may exert some stimulating effect on the central nervous system. Its administration may cause local irritation of the gastric mucosa, with possible gastric discomfort, nausea, and vomiting. The frequency of adverse reactions is related to the serum theophylline level and is not usually a problem at serum theophylline levels below 20 $\mu$g/ml.

**How Supplied:** Capsules in bottles of 100 and 1000 and unit-dose packs of 100; Elixir in bottles of 1 pint and 1 gallon.

See package insert for complete prescribing information.

Mead Johnson

PHARMACEUTICAL DIVISION

©1978 Mead Johnson & Company • Evansville, Indiana 47721 U.S.A. MJL 6-4220R3

# Ask the Consultant

*"Ask the Consultant" is a new IMJ feature. Readers are encouraged to write with clinical questions for which they have not been able to find solutions. The questions will be forwarded to the IMJ Editorial Board. Board members will provide responses, or find specialists to find solutions. Interested readers are asked to write IMJ, 55 E. Monroe, Suite 3510, Chicago 60603. Please specify that your question is for the "Ask the Consultant" column.*

A patient on suppressive INH medication because of a conversion reaction on repeated Tbc skin tests shows elevated liver enzymes after one month on 300 milligrams of INH daily. The dose of INH was reduced by 50% and repeat liver enzymes scheduled for 30 days later. On repeat testing, the enzymes showed considerable improvement although there was still mild elevation in all tests. (For example, the SGOT which normally should be 7-40 mU/ml dropped from 97 to 60 in a month's time.) Does the reduced dose of INH promise to be effective in aborting tuberculosis?

## *Our Editors Respond*

In view of the elevated liver enzymes, the drug should be discontinued entirely since there is no evidence that reduced doses produce effective prophylaxis against active disease. To risk permanent liver impairment in this situation would be extremely foolish.

---

## *EKG*

*(Continued from page 122)*

**Answers: 1. D.E. 2. E.**

The ECG rhythm strip shows a sinus bradycardia with slight sinus arrhythmia with rates varying from 52 to 56 beats per minute. There is a prolonging PR interval to a nonconducted P wave. This progressive lengthening of the PR interval to a blocked P wave is the Wenckebach phenomenon. It is also called a type I second degree AV block. This patient's Wenckebach is atypical with sinus arrhythmia and also because the last PR interval is longest varying from 0.48 to 0.60 seconds. All of the cycles containing the non-conducted P waves also vary slightly from 2040 to 2240 msec. Second degree AV block is common in digitalis toxicity, acute inferior wall myocardial infarction, and rheumatic fever. Our patient was not on digitalis nor did she sustain a myocardial infarction. She did have severe, unstable angina pectoris and hypothyroidism. Her condition was partly stabilized and she underwent coronary arteriography. The left coronary system had only minor disease. However, the right coronary artery was subtotally occluded at its midpoint and was a large dominant vessel, otherwise normal. This single right coronary arteriogram injection caused the patient's angina. Surgical management was considered too risky because of hypothyroidism. Treatment with propranolol 40 mg. Q 6 hours and isosorbide dinitrate 5 mg. Q 4 hours relieved her angina. The angina did not recur with further increases in thyroid medication. With thyroid replacement and despite propranolol, the AV block disappeared. Our conclusion was that the AV block was probably related more to her hypothyroidism than to the ischemic heart disease although both could have contributed.

# CLASSIFIED ADVERTISING

## POSITIONS & PRACTICE OPPORTUNITIES

**FULL TIME PHYSICIAN** for Industrial Clinic in Skokie. Surgical experience needed. Salary negotiable. Must have Illinois license. Call (312) 674-4800, Mrs. McCubbin.

**OPPORTUNITIES FOR PHYSICIANS IN INDIANA**—There are several excellent openings among the Indiana State Hospitals at various locations throughout the state for psychiatrists and physicians of other specialties, at most experience levels. A newly-revised salary schedule offers a very competitive income plus a generous package of fringe benefits. An adjunct practice is possible beyond the regular working hours and on-call responsibilities. Please reply with a copy of the c.v. to: Farabee & Associates, Inc., P.O. Box 472, Murray, KY 42071 or call (collect) (502) 753-9772. Farabee is retained by the Indiana Department of Mental Health.

**ACADEMIC DIRECTOR, INTERNAL MEDICINE:** University of Illinois affiliated community hospital seeks individual to be responsible for undergraduate, graduate and continuing medical education, and administration of residency and outpatient center. Physician we seek must be American Board of Internal Medicine certified. In return we offer a challenging and rewarding experience plus a competitive salary and benefit program. Send resume in complete confidence to: Box 917, c/o IMJ, 55 E. Monroe, Suite 3510, Chicago 60603.

**WANTED: INDUSTRIAL PHYSICIAN:** Unusual opportunity for Illinois licensed physician. Full time industrial work with minor traumatic surgery and physical examinations. Regular hours. Advancement for right person. Starting salary negotiable. Write to Box 920, c/o IMJ, 55 E. Monroe, Suite 3510, Chicago, 60603.

**ENT SPECIALIST** needed in a large, fast growing Chicago suburb. No other ENT specialist in town. Very favorable terms. Send resume to Box 926, c/o IMJ, 55 E. Monroe, Chicago, Illinois 60603.

**DERMATOLOGIST** needed for a large, fast growing Chicago suburb. Solo practice. Ideal for a second office. Office space available in a new medical complex. Very favorable terms. Send resume to Box 928, c/o IMJ, 55 E. Monroe, Chicago, Illinois 60603.

**EMERGENCY DEPARTMENT PHYSICIAN:** Become part of an expanding, dynamic multispecialty clinic in midwest university community of 100,000. Excellent salary, benefits. Write or call Medical Director, Carle Clinic, Urbana, IL 61801, (217) 337-3239.

**FAMILY PRACTITIONER**—To associate with one senior general practitioner and one surgeon in rural southern Illinois. Excellent educational system and recreation. Financially sound community. One hour from St. Louis. JCAH 72-bed hospital in Nashville. Association available now. Contact: T. K. Janssen, Administrator, Washington County Hospital, Nashville, Illinois, (618) 327-8236.

**PRIMARY CARE PHYSICIAN:** We seek a primary care physician, specialist or generalist, for JCAH-accredited hospital in central Illinois. Population: 4,500—service area 19,000. Hospital affilated with a major medical center and teaching hospital which provides opportunities for continuing medical education and support activities, ensuring against professional isolation. Hospital will furnish office in building on grounds and guaranteed base salary, plus other amenities. For further information write: Box 931, c/o IMJ, 55 E. Monroe, Suite 3510, Chicago, Ill. 60603.

**FAMILY PRACTICE PHYSICIAN** who is interested in obstetrics wanted to do primary care. $42,000 plus fringes (IRS-approved profit sharing plan) to start. Contact H. Osmus, Administrator, Hedges Clinic S.C., 222 Colorado, Frankfort, IL 60423; or (815) 469-2123.

**ILLINOIS—PEORIA**—Interviewing career Emergency Physicians for full-time openings starting immediately and Jan. 1. Opportunity to join young ACEP oriented physicians' group in 550-bed Medical-Surgical Hospital affiliated with Peoria School of Medicine. Good specialty backup. Flexible scheduling. Superior compensation with liberal fringe benefits including malpractice. Contact H. T. Stratton, M.D.; Methodist Medical Center, 221 NE Monroe, Peoria, IL 61636; (309) 672-4974 or (309) 672-5501.

**CHILD PSYCHIATRIST**—Full or part time. Modern residential treatment center for children & adolescents. Write or call Jose R. Sanchez, M.D., Medical Director, Chicago-Read Mental Health Center, 4200 N. Oak Park Ave., Chicago, Ill. 60634. (312) 794-4000.

**PEDIATRICIAN**—Full or part time. Modern residential treatment center for children & adolescents. Write or call Jose R. Sanchez, M.D., Medical Director, Chicago-Read Mental Health Center, 4200 N. Oak Park Ave., Chicago, Ill. 60634. (312) 794-4000.

**PSYCHIATRIST**—Adult Inpatient Services. Full or part time, for modern residential facility: Write or call Jose R. Sanchez, M.D., Medical Director, Chicago-Read Mental Health Center, 4200 N. Oak Park Ave., Chicago, Ill. 60634. (312) 794-4000.

**GENERAL PRACTITIONER, FAMILY PRACTITIONER,** needed for rural Illinois town near metropolitan area. Private office, full equipment and established practice available for sale or lease. Write: James R. Hastings, Executor, 301 NW 2nd St., Aledo, Illinois 61231, or telephone (309) 582-5388.

**PSYCHIATRIST, OR PHYSICIAN WITH PSYCHIATRIC EXPERIENCE:** Salary $32,000 to $44,450 depending on training, experience and current earnings. Additional monies available by working O.D. Time. Excellent fringe benefit package. Serve as team physician in moderate sized Illinois psychiatric facility located in northwestern Illinois on the Mississippi River in the Moline, Rock Island, Davenport, metro-plex. Excellent cultural, recreational, and educational facilities in community. Emphasis is on short-term treatment in this fully JCAH accredited facility. Must possess Illinois license or be eligible for reciprocal licensure. Equal Opportunity Employer. Send resume to: K. D. Dimitri, M.D., Superintendent, East Moline Mental Health Center, 100 Hillcrest Road, East Moline, Illinois 61244.

**PHYSICIAN WANTED.** Full or part time for fully equipped medical center. Large welfare practice. 2823 N. Clybourn, Chicago, Ill. 60618. Telephone—(312) 929-6999 or 664-3157.

**OCCUPATIONAL MEDICINE**—National corporation needs associate medical director in Skokie, Illinois; occupational medical experience desirable. Corporation dedicated to comprehensive health program for all employees; modern well equipped facilities; liberal fringe benefits include life and health insurance, excellent savings plan, malpractice insurance coverage, liberal vacation, holiday and sick leave policies, etc.; salary commensurate with position responsibilities, experience and professional training. Send resume in confidence to Box 935, c/o Illinois Medical Journal. An Equal Opportunity Employer.

**PHYSICIAN WANTED:** General medical services to be provided to psychiatric patients. Full and part-time positions available. Generous fringe benefits. Salary negotiable. 50 minutes from downtown Chicago. Contact Claude Roush, Superintendent, Manteno Mental Health Center, Manteno, Illinois 60950. (815) 468-3451.

**FAMILY PRACTICE PHYSICIAN** needed immediately to cover practice of well-established physician during period of illness, in East Moline, Illinois. Coverage needed for approximately six months after which take over of practice might be possible. Or, establishment of own practice in facilities available adjacent to Illini Hospital. For further details including financial information contact Brian P. Bollman, Assistant Administrator, Illini Hospital, Silvis, Illinois 61282. Area Code (309) 792-9363.

**GENERAL PRACTITIONER:** Urgent need for 2 physicians, Illinois license required, in a 420 bed fully accredited state facility for developmentally disabled; salary range $31,400 to $41,535 but is negotiable; good working conditions and excellent fringe benefits; paid vacations, accumulative sick time, free life and health insurance; well established continuing medical education program provided by SIU Medical School; located in west-central Illinois, 30 minutes from Springfield; good schools, two colleges; contact William K. Murphy, Superintendent, Jacksonville Mental Health & Developmental Center, 1201 South Main St., Jacksonville, Illinois 62650, telephone (217) 245-8715.

**GENERAL SURGEON:** The Department of Surgery, Peoria School of Medicine, University of Illinois College of Medicine is seeking a Clinical Instructor or Assistant Professor to participate in programs of health professions education. The appointment is for 25% time. Candidates must be qualified or eligible for examination by the ABS. The University of Illinois is an Affirmative Action-Equal Opportunity Employer and encourages applications from members of minority groups and women. Closing date for applicants is September 30, 1978. Send letter with curriculum vitae to: William H. Marshall, M.D., Acting Chairman, Department of Surgery, Peoria School of Medicine, 123 S.W. Glendale Avenue, Peoria, IL 61605.

**DIAGNOSTIC RADIOLOGIST:** A.B.R. qualified; one year training in general surgery necessary; proficient in angiography and nuclear medicine. $4,000.00 per mo. Contact Dr. Farmer, St. Anthony's Hospital, Effingham, IL.

**LOCUM TENENS; PART TIME**—Multi-hospital group has available occasional part time work for Illinois or Indiana licensed physicians. Income varies according to physicians schedule; flexible scheduling. Contact Dr. Cooper's office toll free for details, 1-800-325-3982.

**LOCUM TENENS—EMERGENCY MEDICINE**—available in our 100 hospitals; monthly scheduling is flexible and according to your preferences; malpractice is paid, excellent hourly income according to your flexibility and hours worked. Call toll free 1-800-325-39B2, ext. 220 for details.

## FOR SALE, LEASE OR RENT

**MEDICAL OFFICE SUITE FOR RENT,** Lincoln-8elmont Bldg. 715-1200 square feet, available at once in full service, elevator, active professional building. Call Gary Solomon, (312) 334-5400.

**MEDICAL CENTER FOR RENT.** Complete and ready to open. 4300 sq. ft. at 2301 E. 95th Street, Chicago. Large waiting rm., 18 exam rms., x-ray rm., central a/c & heat. Call Gary Solomon, (312) 334-5400.

**SUITE TO LEASE** for Internist, Pediatrician, Psychologist, Psychiatrist or other medical practice. Suite is located in a high quality building with a growing medical community situated across from a major hospital. The complex already includes an outstanding lab, X-ray facility, pharmacy and 16 professionals. Arrangement provides flexibility for the new tenant to share a suite with an existing practice, to have office built in newly created bare space and to participate in the ownership and direction of the complex. STRONG Property Managers, Ltd. Agents, 201 W. Springfield, Champaign, IL 61820. (217) 356-2617.

**FOR SALE:** 31-year-old established general practice and clinic. Fully equipped and furnished. Clinic and practice can accommodate two doctors. Contact: 8ob 8illa, 2931 East Southcross 8lvd., San Antonio, Texas 78212.

**LISLE-MEDICAL SUITE** available in prestigious modern building located on Rt. 53 in Lisle. X-ray facilities on premises. Zone controlled heating and air conditioning. Ample parking. Call 969-2850.

**FOR SALE:** Solo or Group Practice/south western Chicago suburb. Comprehensive Medical Center: Internal Medicine, O8-GYN, Pediatrics, Optometry, Dental, X-ray Equipment, Medical Lab and Pharmacy. 7000 sq ft., 15 fully equipped examining rooms plus business offices. Private parking. Estimated Annual Gross Income: middle six figures. Negotiable financing. Outstanding opportunity with excellent potential. Please direct inquires to: 8ox #933, c/o **ILLINOIS MEDICAL JOURNAL,** 55 E. Monroe, Chicago, IL 60603.

**GENERAL PRACTICE FOR SALE:** Excellent quality practice including industrial medicine. Northwest Suburban location with community hospital. Sale due to illness — Seller will assist in transition with hospital privileges, employees, etc. Contact Mark Gorman at 3916-67th Street, Kenosha, Wisconsin 53142. 414-654-9166.

**FOR SALE:** 1. Mattern x-ray machine 300 MA, 110 KV radiographic & fluoroscopic unit rotating anode tube with electronic timer; MEDALIST-300. 2. Upright fluoroscopic unit; 3. Dark-room equipment and accessories. PH: (312) 726-8381. HRS: 1 to 4, except Wednesday.

**RANCH-STYLE MODERN MEDICAL-DENTAL BUILDING FOR RENT OR SALE:** Customized facilities to meet every medical and dental need. Ideal for family physician or group practice. 1500 to 2500 sq. ft. available. Armitage and Damen area, Chicago. Near St. Mary of Nazarene Hospital. Excellent location for neighborhood practice. (312) 472-5126 or 338-9347.

**FOR SALE:** 100 Mili-amp X-ray machine complete with fluoroscopic screen and developing tanks. Contact Wilson L. DuComb, M.D., 560-8th Street, Carlyle, Illinois 62231. Phone (618) 594-3451.

**INVESTMENTS:** Some choice MINI-SHOPPING CENTERS in the southwestern Chicago suburbs have come on the market. They have AAA tenants. One has a very attractive mortgage. Please call or write; Harrald E. Hayford, 1121 W. Ogden Avenue, Naperville, IL. (312) 420-2777.

**MEDICAL SUITES AVAILABLE,** near north side of Chicago, Logan square area, (312) BE5-7000, Mr. Fein.

**INGALLS MEMORIAL HOSPITAL**—New professional building, Harvey, Ill. Suites to doctors specifications. Housekeeping, maintenance, utilities included. Ample patient parking. Enclosed walkway to hospital. McKey & Poague Agents. (312) 331-4226.

**OPPORTUNITIES FOR PHYSICIANS IN CHICAGO WESTERN SUBURB:** Unique new medical office condominiums under construction in Wheaton/Carol Stream. Anticipated occupancy February, 1979. Opportunity to lease, purchase or lease with an option to purchase. Situated adjacent to existing Professional Park housing 35 physicians. Call (312) 665-9777 for details or brochure.

## SITUATIONS WANTED

**BOARD CERTIFIED RADIOLOGIST,** 40, graduate of American medical school available for film reading in office, clinic or home. Daily pick-up service if desired. Excellent references. Please contact Illinois Medical Journal, Box No. 930, 55 East Monroe, Chicago, Illinois 60603.

**INTERNIST**—29, university trained seeks partnership or group practice opportunity in Chicago area. Available July 1979. 8ox 929 or phone (312) 2B0-1156 after 6 pm.

**CERTIFIED PHYSICIAN'S ASSISTANT** with excellent medical, research and administrative background and experience. Available for Chicago or suburbs. Reply Box 934, c/o Illinois Medical Journal, 55 E. Monroe, Chicago, IL 60603.

## MISCELLANEOUS

**REAL ESTATE MANAGEMENT:** You are a professional but are you a professional landlord? We are Professional Landlords who can manage your property completely so that you can devote full time to your profession. If you own apartment complexes, office buildings or shopping centers, our management skills can reduce your expenses and maximize your cash flow. COMBINED CAPITAL ASSOC., Suite 2015 Tribune Tower, 435 No. Michigan Ave., Chicago, IL 60611. Tel. (312) 337-6655.

## GUARANTY FUND CERTIFICATE

**GUARANTY FUND CERTIFICATE:** Class 8 Inter-Insurance Exchange Certificate for sale (previously class 5). Call 266-1977, 9-5 P.M.

**GUARANTY FUND CERTIFICATE**—Anesthesiologist relocating, Class 5, 1,000,000/1,000,000 coverage. Original price 10,000—purchase price 8000.00 or best offer. Favorable conditions may be arranged. Send inquiries to Box 922, c/o IMJ, 55 E. Monroe, Suite 3510, Chicago, 60603.

**FOR SALE:** Illinois Medical Inter-Insurance Exchange Guaranty Fund Certificate, 100,000/300,000, Class 1, Terr. I. Cost 1977, one thousand-thirty two dollars ($1032.00). Contact: Hans F. Waecker, D.O., 5200 S. Ellis Ave., Chicago 60615.

**GUARANTY FUND CERTIFICATE:** Wanted to purchase-Guaranty Fund Certificates for the Illinois State Medical Inter Insurance Exchange—call (312) 423-4499.

**GUARANTY FUND CERTIFICATE** for Territory II, Class 3—amount $2572.00—for sale. Please contact: V. J. Kelly, M.D., Cisco Lake Road, Watersmeet, MI 49969; (906) 35B-4640.

**GUARANTY FUND CERTIFICATE,** No. 214, Illinois State Medical Inter-Insurance Exchange. Contact James R. Hastings, Executor, Estate of James W. Hastings, M.D., 301 NW 2nd Street, Aledo, Illinois 61231. Phone 309-582-5388.

**GUARANTY FUND CERTIFICATE** for sale: Class 5, territory II for $1,000,000/$1,000,000 coverage, purchase price $6.024.00. For sale for $4,500.00. For information call (816) 364-5255, or write to Professional Anesthesia Services, Inc., 416 North Seventh, St. Joseph, MO 64501.

**WANTED TO PURCHASE**—Guaranty Fund Certificate—Class VI—Illinois State Medical Inter-Insurance Exchange. Please contact Mrs. Yost—(312) 596-7070.

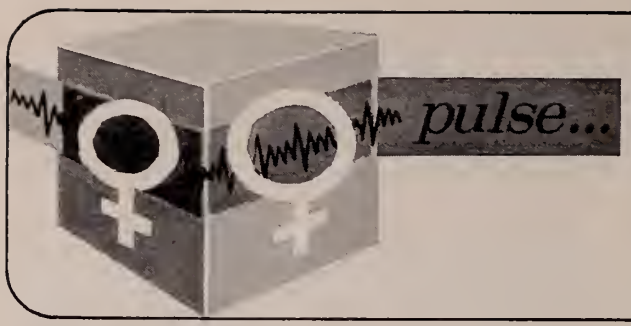
**FOR SALE:** Illinois Medical Inter-Insurance Exchange Guaranty Fund Certificate, 100,000/300,000, Class 2, Terr. 2. Purchase price $876.00. Contact: Dr. Helmut Hartmann, Box 88, Frohna, Mo. 63748. Phone: (314) B24-5225.

**GUARANTY FUND CERTIFICATE** for sale. Face Value $776. Discount. M. E. Godbey, M.D., 505 N. Grove, Normal, Illinois 61761. (309) 452-2010.

**ILLINOIS STATE MEDICAL** Inter-Insurance Exchange Guaranty Fund Certificate for sale. Territory 1, Class 2. Original price $980.00. Best offer. Contact: Mrs. Berger (312) 272-0724.

**GUARANTY FUND CERTIFICATE,** original price $3,096.00, will discount, call 312-226-3742.

*IMJ and ISMS are not acting as brokers or agents; this is provided as a membership service.*



# pulse... of the ISMS auxiliary

Mrs. Eugene Vickery, Editor



## Growth Patterns

**Auxiliary "Bits and Pieces"**

Mrs. Earl V. Klaren, President, ISMSA

As an auxiliary member *you* are a vital part of a not-for-profit, volunteer service organization comprised of more than 80,000 physicians wives in 1,050 counties in 50 states and the District of Columbia.

*What have you helped accomplish by being a member?*

In one year alone, auxiliary members across the country worked on

- 606 programs for the aging
- 272 health careers projects
- 329 immunization programs
- 112 programs to help combat child abuse
- 227 counseling programs to aid in crisis situations
- 107 emergency medical care programs
- 129 safety programs
- 359 screening programs for vision, hearing and other physical problems. These figures only touch the surface in terms of people helped and volunteer hours given. It takes a large PROJECT BANK book to begin to enumerate the variety of projects and programs carried out by auxilians.

*Record breaking contributions of over $2 million were made to AMA-ERF* this past year (1977). This represented more than 48,000 individual contributions. Dr. Hubert A. Ritter, president of AMA-ERF, thanked auxilians for their leadership, hard work, and dedication to continuing excellence in medical education. Just over half this amount was ear-marked for medical schools. Increased attention paid to the Guaranteed Student Loan Fund paid off. Almost $260,000 was donated to this fund, a substantial improvement over the $77,000 contributed the previous year. Despite these gains, the escalating costs of a medical education mean that the loan fund needs even more attention in the coming year, Dr. Ritter said.

Illinois State Medical Society and Auxiliary topped the nation in state contributions again this year and our goal is to do the same in 1978-79.

*Legislation*—Hundreds of letters have been written by auxiliary members to members of congress urging the passage of sound health-related legislation to help ensure quality medical care for all people. Promote legislative awareness through specific workshops and briefings in 78-79!

*Nationwide Immunization Campaigns* initiated last year have produced sharp drops in childhood diseases, the Department of Health, Education, and Welfare recently reported. The most dramatic change has been the 65% decline in the number of reported measles cases. *Auxilians do help make a difference.*







Three of the first auxiliary officers were present at the Stephenson County Auxiliary silver luncheon (far left photo). Left to right: Mrs. Charles Zipf, 1953 vice president, Mrs. E. F. Kortemeier, 1953 treasurer and Mrs. Carl Becker, 1953 president. (Mrs. C. E. Rideout, 1953 secretary, who has moved to California, is absent in this photo). . . . The leaders of the American Medical Association Auxiliary this year are (center photo) Mrs. Manuel A. Bergnes, (right) president and Mrs. Ben Johnson, Jr., (left) president-elect. In her inaugural address in June, Mrs. Bergnes told the AMA Auxiliary representatives: "We are an organization of people with values, which makes us care about what happens to people, and makes us work to improve the quality of life. . . . We must maintain the value we believe in and work harder than ever to put them into action. . . . Not only do we care about what happens to the health of people in this country, we are willing to volunteer our time and talents to put those values into action," . . . This year's ISMSA leaders (far right photo) are Mrs. Earl Klaren, (seated) president and Mrs. R. S. Hoover, president-elect. They seek the support and cooperation of all Illinois auxiliary members to make this an even greater year by focusing their individual talents, training and expertise on all phases of community life. "Your volunteered time as auxiliary members has made a difference, in one way or another, to bring quality health care to people all over the state of Illinois. It is my hope that all members will work even harder to make our 51st year a banner one!" Mrs. Klaren told the group.

# INDEX TO ADVERTISERS


## Pharmaceuticals

| | |
|---|---|
| 174 | **Breon Laboratories**<br>*Bronkodyl* |
| 124-125 | **Bristol Laboratories**<br>**Div. of Bristol-Myers Co.**<br>*Tegopen* |
| Cover 2 | **Burroughs Wellcome Co.**<br>*Empirin* |
| 133 | **Eli Lilly & Company**<br>*Keflex* |
| 167-168 | **Mead Johnson**<br>**Pharmaceutical Division**<br>*Vasodilan*<br>*Quibron* |
| Covers 3-4 | **Roche Laboratories**<br>**Div. of Hoffman-LaRoche**<br>*Librium* |
| 119 | **Roche Laboratories**<br>**Div. of Hoffman-LaRoche**<br>*Valium* |
| 134 | **Upjohn Pharmaceuticals**<br>*Tolinase* |

## Insurance

| | |
|---|---|
| 159 | **Medical Protective Co.**<br>*Professional Liability Ins.* |
| 153 | **Parker Aleshire and Co.**<br>*Group Insurance* |

## Services and Continuing Education

| | |
|---|---|
| 127-128 | **Blue Cross and Blue Shield Report** |
| 170 | **Classified Advertising** |
| 137 | **Cook County Graduate School**<br>*Continuing Medical Education* |
| 163 | **Illinois Medical Political Action Committee** |
| 130 | **INTRAV**<br>*African Adventure* |
| 164 | **ISMS Guide to Continuing Medical Education** |
| 155 | **Mann, Levine & Weiss**<br>*Pension Consultants* |
| 153 | **Medenco Hospital Corp.**<br>*Position Opportunities* |
| 139 | **Ravenswood Hospital**<br>*Position Opportunities* |


*Our advertisers serve the Medical Profession and support your Journal. All advertisers are approved by your Journal Committee. It will help you and your society to mention your Journal when writing them.*

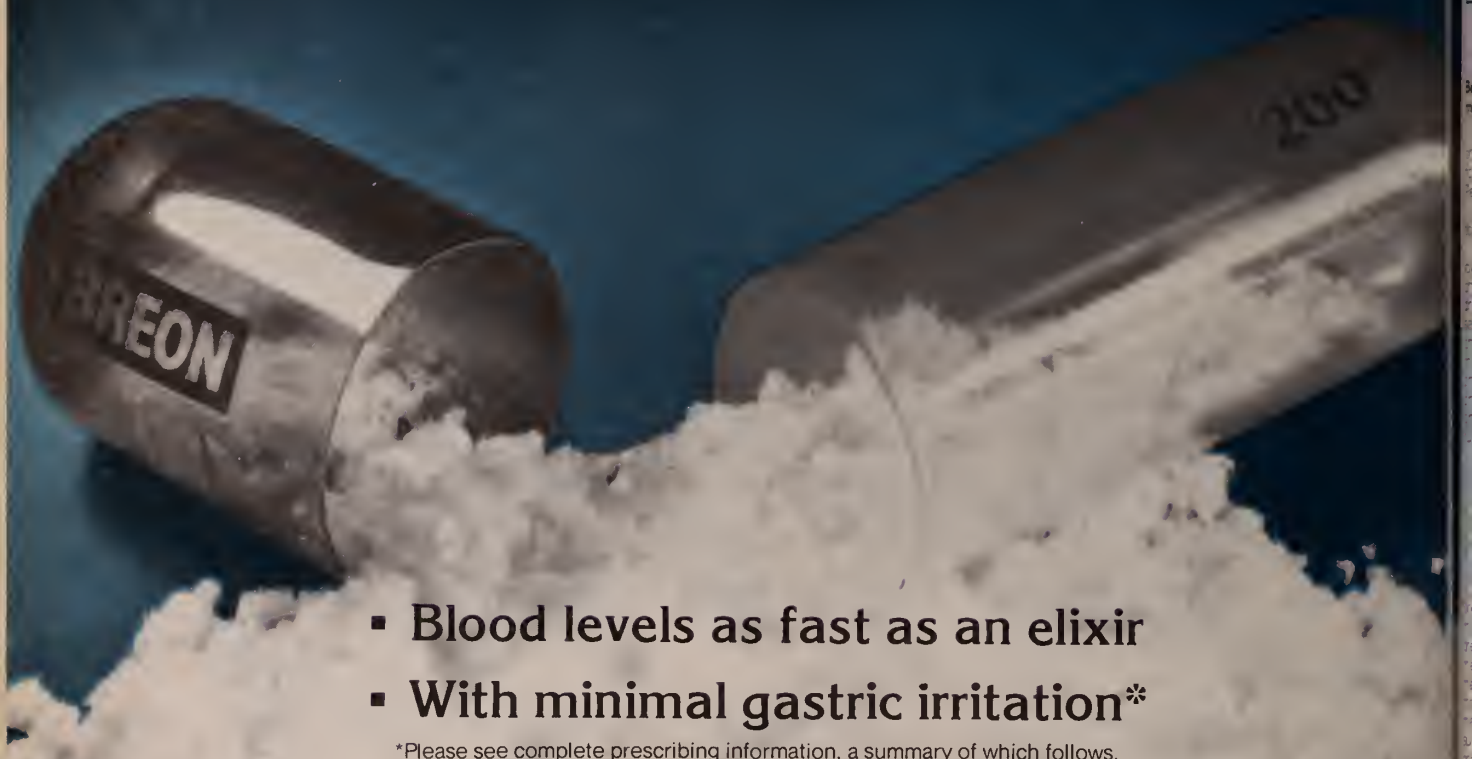
*Space Representatives:* United Media Associates, Inc., 16 Bruce Park Avenue, Greenwich, Conn. 06830

# A Difference in Theophylline Therapy

## micro-pulverized

# BRONKODYL® Capsules

brand of theophylline, USP anhydrous




- Blood levels as fast as an elixir
- With minimal gastric irritation*

*Please see complete prescribing information, a summary of which follows.

DESCRIPTION:
Each green and white hard gelatin capsule contains theophylline USP anhydrous, 200 mg., in a micro-pulverized form. Each brown and white hard gelatin capsule contains 100 mg. The elixir contains 80 mg. theophylline per 15 ml. in a 20% alcohol elixir (approximately 20 calories, 0.9 gm carbohydrate per tablespoonful).

ACTION: Theophylline is a methylxanthine which relaxes the smooth musculature of the bronchioles through its inhibition of the conversion of cyclic adenosine monophosphate to adenosine monophosphate by phosphodiesterase. It also has diuretic, cardiotonic, and CNS stimulant effects.

INDICATIONS: Bronkodyl is indicated for symptomatic relaxation of bronchiolar spasm in the chronic obstructive bronchopulmonary diseases; e.g., bronchial asthma, chronic bronchitis and pulmonary emphysema.

CONTRAINDICATIONS: Bronkodyl is contraindicated in persons known to have had serious idiosyncratic responses to theophylline, its salts, or the other methylxanthines, theobromine, or caffeine and may be contraindicated in peptic ulcer.

WARNINGS: All methylxanthines should be used with caution in children and in others who are currently taking bronchodilator products, especially in rectal dosage form, which may contain theophylline or related drugs.

USAGE IN PREGNANCY: Although theophylline has been used for many years, with no evidence of adverse fetal effect or teratogenicity, its safety in pregnancy has not been established. Therefore use of Bronkodyl during lactation or in women of childbearing potential requires that possible benefits of the drug be weighed against possible hazards to fetus or child.

PRECAUTIONS: Bronkodyl should be used with caution in patients with cardiac or circulatory disease.

ADVERSE REACTIONS: Gastrointestinal: Epigastric distress, nausea, vomiting. Cardiovascular: palpitations. CNS: Insomnia, restlessness, irritability, convulsion.

DOSAGE AND ADMINISTRATION: Adults: Usual dosage of Bronkodyl is 200 mg. every 6 hours (four doses in each 24 hours). This dosage may be adjusted to reflect individual clinical response as an indication of slow or rapid metabolism of the drug. If adverse reactions are encountered, each dose may be reduced, or the interval between doses may be lengthened, or both. If clinical response is not satisfactory, indicating possible rapid inactivation of the drug, dosage may be gradually increased to achieve the desired response. In some instances of either too slow or too rapid metabolism, plasma levels of theophylline should be determined and dosage adjusted accordingly to achieve levels above 10 mcg/ml, but not to exceed 20 mcg/ml.

Dosage in Children: Usual dosage should be based on administration of 10 mg per kg per 24 hours, divided in 4 doses per day, given every 6 hours. As this may not be possible with use of the capsules, Bronkodyl elixir may be used. Theophylline saliva levels (approximately 60% of simultaneous blood levels), may facilitate dosage adjustments, especially in children, to obtain appropriate response.

HOW SUPPLIED:
Bronkodyl 100 mg., brown and white capsules in 100's, Code #1831.
Bronkodyl 200 mg., green and white capsules in 100's, Code #1833.
Bronkodyl Elixir, 80 mg. per 15 ml, in pints, Code #1835.

BREON BREON LABORATORIES INC.
90 Park Avenue, New York, N.Y. 10016

# Librium®
## chlordiazepoxide HCl/Roche



5mg, 10mg, 25mg capsules

- ☐ Proven antianxiety performance
- ☐ An unsurpassed safety record
- ☐ Predictable patient response
- ☐ Minimal effect on mental acuity at recommended doses
- ☐ Minimal interference with many primary medications, such as antacids, anticholinergics, diuretics, cardiac glycosides and antihypertensive agents

**Before prescribing, please consult complete product information, a summary of which follows:**

**Indications:** Relief of anxiety and tension occurring alone or accompanying various disease states. Efficacy beyond four months not established by systematic clinical studies. Periodic reassessment of therapy recommended.

**Contraindications:** Patients with known hypersensitivity to the drug.

**Warnings:** Warn patients that mental and/or physical abilities required for tasks such as driving or operating machinery may be impaired, as may be mental alertness in children, and that concomitant use with alcohol or CNS depressants may have an additive effect. Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported.

**Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

**Precautions:** In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

**Adverse Reactions:** Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

**Usual Daily Dosage:** Individualize for maximum beneficial effects. Oral—Adults: Mild and moderate anxiety and tension, 5 or 10 mg t.i.d. or q.i.d.; severe states, 20 or 25 mg t.i.d. or q.i.d. Geriatric patients: 5 mg b.i.d. to q.i.d. (See Precautions.)

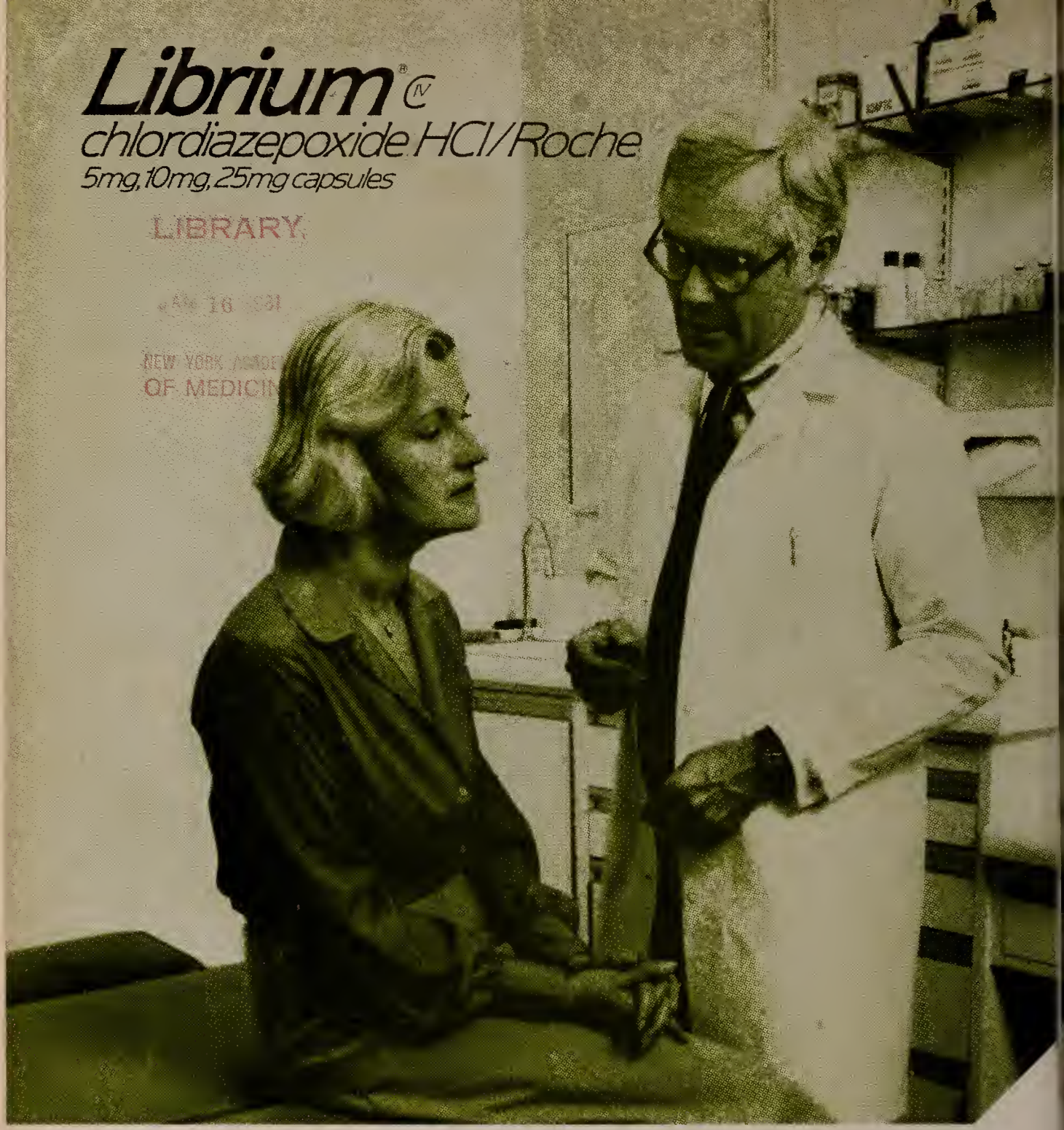
**Supplied:** Librium® (chlordiazepoxide HCl) Capsules, 5 mg, 10 mg and 25 mg—bottles of 100 and 500; Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10; Prescription Paks of 50, available singly and in trays of 10. Libritabs® (chlordiazepoxide) Tablets, 5 mg, 10 mg and 25 mg—bottles of 100 and 500. With respect to clinical activity, capsules and tablets are indistinguishable.

# synonymous with relief of anxiety

ROCHE

Roche Products Inc
Manati, Puerto Rico 00701

**Please see following page.**




LIBRARY,
NEW YORK ACADE
OF MEDICIN

synonymous with relief of anxiet

ROCHE

Please see preceding page for a summary of product information.

IMJ
Illinois Medical Journal
OFFICIAL JOURNAL OF THE ILLINOIS STATE MEDICAL SOCIETY
ume 154, Number 4 - October 1978

BALCONY

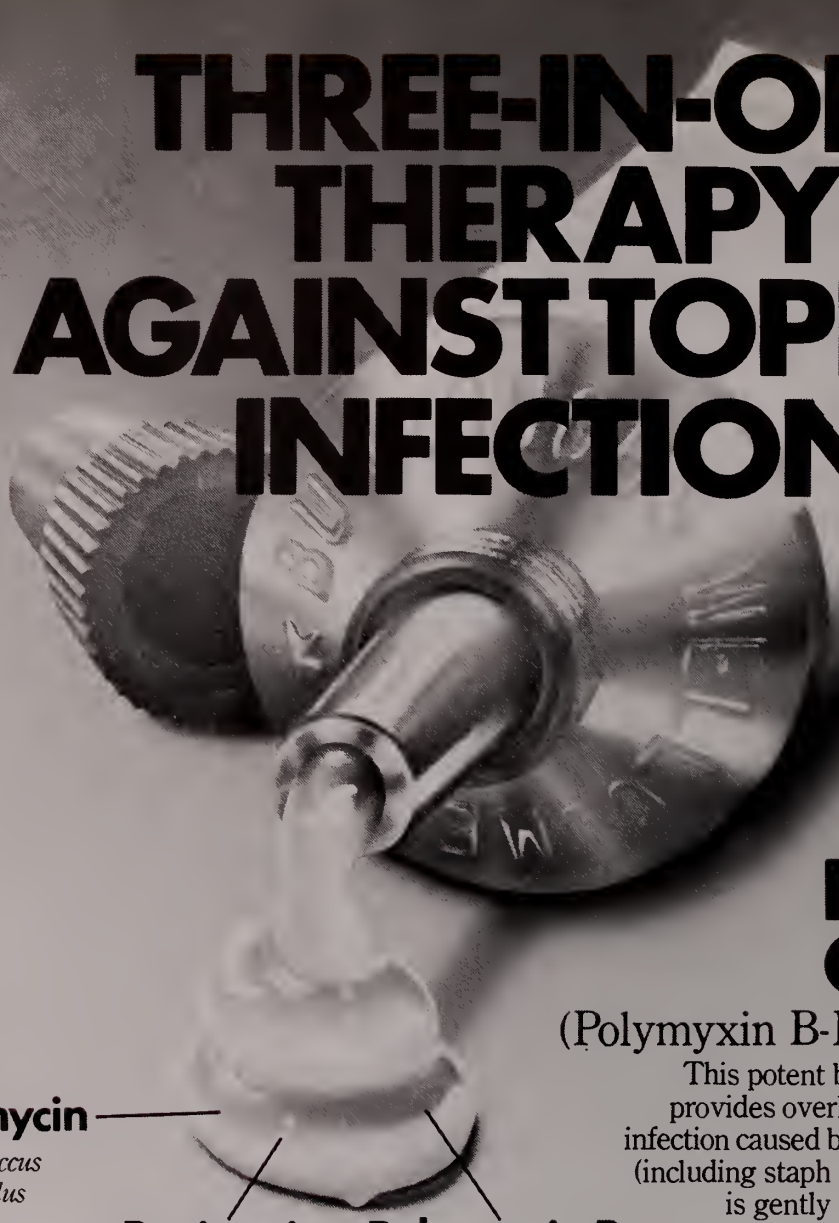
CHIEF OF [illegible]
RIVERSIDE HOSP.
350 N. WALL ST. BOX 712
KANKAKEE, IL 60901

# Reference Issue

REFERENCE ISSUE SECTION—PAGE 203

nvention Handbook - 295
IMPAC Message - 291
Table of Contents - 177
President's Page - 313

# THREE-IN-ONE THERAPY AGAINST TOPICAL INFECTION



## Neosporin Ointment

(Polymyxin B-Bacitracin-Neomycin)

This potent broad-spectrum antibacterial provides overlapping action to help combat infection caused by common susceptible pathogens (including staph and strep). The petrolatum base is gently occlusive, protective and enhances spreading.

**Neomycin**

*Staphylococcus*
*Haemophilus*
*Klebsiella*
*Aerobacter*
*Escherichia*
*Proteus*
*Corynebacterium*
*Streptococcus*
*Pneumococcus*

**Bacitracin**

*Staphylococcus*
*Corynebacterium*
*Streptococcus*
*Pneumococcus*

**Polymyxin B**

*Pseudomonas*
*Haemophilus*
*Klebsiella*
*Aerobacter*
*Escherichia*

*In vitro* overlapping antibacterial action of Neosporin® Ointment (polymyxin B-bacitracin-neomycin).

Wellcome

Burroughs Wellcome Co
Research Triangle Park
North Carolina 27709

---

## Neosporin® Ointment

(Polymyxin B-Bacitracin-Neomycin)

Each gram contains: Aerosporin® brand Polymyxin B Sulfate 5,000 units; zinc bacitracin 400 units; neomycin sulfate 5 mg (equivalent to 3.5 mg neomycin base); special white petrolatum qs; in tubes of 1 oz and 1/2 oz and 1/32 oz (approx.) foil packets.

**WARNING:** Because of the potential hazard of nephrotoxicity and ototoxicity due to neomycin, care should be exercised when using this product in treating extensive burns, trophic ulceration and other extensive conditions where absorption of neomycin is possible. In burns where more than 20 percent of the body surface is affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended.

When using neomycin-containing products to control secondary infection in the chronic dermatoses, it should be borne in mind that the skin is more liable to become sensitized to many substances, including neomycin. The manifestation of sensitization to neomycin is usually a low grade reddening with swelling, dry scaling and itching; it may be manifest simply as failure to heal. During long-term use of neomycin-containing products, periodic examination for such signs is advisable and the patient should be told to discontinue the product if they are observed. These symptoms regress quickly on withdrawing the medication. Neomycin-containing applications should be avoided for that patient thereafter.

**PRECAUTIONS:** As with other antibacterial preparations, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

**ADVERSE REACTIONS:** Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section).

Complete literature available on request from Professional Services Dept. PML.

Blue Cross®
Blue Shield®

# REPORT FOR *Illinois Physicians*

## Utilization of Cost-Effective Programs

Illinois Blue Cross and Blue Shield is urging physicians, hospital administrators and all providers of patient care to utilize as extensively as possible the Plan's cost effective programs to conserve hospital and medical care expenses.

In the August issue of the "Blue Cross and Blue Shield Report for Illinois Physicians," the Pre-Admission Testing program for surgical patients (PAT) and the Ambulatory Surgery program were described and their cost-saving advantages emphasized.

Two additional cost-effective programs of the Plan—Coordinated Home Care and the Extended Care Facility program—are summarized below:

Further information on these programs is available from the Public Relations Department of Blue Cross and Blue Shield, 233 North Michigan Ave., Chicago, Illinois 60601.

*Coordinated Home Care:* Many hospital patients are going home earlier, because of Blue Cross and Blue Shield's Coordinated Home Care benefit program. With the doctor's permission, patients who are Blue Cross-Blue Shield members may be released directly into a program of recuperation and treatment at home where further medical and nursing care is provided.

The program is coordinated through the participating hospital in which the patient is receiving care and a participating Home Health Agency. It serves a two-fold purpose: The patient recuperates in the comfortable surroundings of his home, and the costs of care are reduced substantially in eliminating the expenses of a prolonged hospital stay.

A total of 58 hospitals and 32 home nursing agencies participate in this program. Many Blue Cross and Blue Shield subscribers are automatically covered for Coordinated Home Care.

To be eligible for the program, a patient must be directed into the program by his or her physician; require nursing service with continued hospital services or supplies; have inpatient hospital benefit days available under Blue Cross and doctor visits available under Blue Shield; be discharged from the hospital directly into the program; want to be cared for at home, have an adequate home situation; and require care directly related to the condition that required hospitalization.

Blue Cross will pay for the services of a visiting nurse and physical therapy from the participating agency and for such services as medication, dressings, medical supplies, lab tests and x-rays from a participating hospital.

Blue Shield will pay the Usual and Customary fee of the attending physician for visits to the patient's home and for one office visit while the patient is under the Coordinated Home Care program.

The maximum number of Coordinated Home Care visits allowed are three for each unused hospital benefit day in a subscriber's Blue Cross certificate. For example, if a certificate provides for 120 days of hospital benefits and only 60 days are spent in the hospital, the patient has 180 eligible days for Coordinated Home Care, provided the need is acute and vertified by the attending physician. Each visit by the attending physician counts as one benefit day. In all cases, vertification of need is required every 30 days.

*Extended Care Facility Program:* Blue Cross and Blue Shield's Extended Care Facility program is designed to maintain quality care while holding down costs. An Extended Care Facility is a specially qualified facility staffed and equipped to provide comprehensive post-acute hospital and rehabilitative inpatient care after an early transfer from a hospital. It must have a contract with the Plan at the time the Blue Cross member is admitted.

An Extended Care Facility may be recommended for a patient after surgery or a serious illness when the extensive services of a general hospital are not required for a successful recovery. A supportive or maintenance level of care, residential care and custodial care are not covered.

The Extended Care Facility program increases the amount of benefit days for Blue Cross and Blue Shield subscribers. Benefits entitle the patient-subscriber to two days of care for each unused hospital benefit day under Blue Cross. Blue Shield pays for physician visits on the same basis as inhospital visits—with each visit counting as one daily visit.

A total of 57 facilities now qualify as Blue Cross-approved Extended Care Facilities. The names and locations of the facilities are available from Blue Cross and Blue Shield.

## Daily Visit Charges for Inpatient Hospital Visits

Physicians frequently submit Medicare claims, or bill their patients, for hospital visits charging a single, inclusive daily visit rate for each day the patient is hospitalized. If a patient is hospitalized for 30 days, for instance, the charge would be for 30 visits.

*It is the responsibility of the physician to provide adequate documentation of these visits;* an entry should be made in the hospital record that indicates the date of each visit. Physicians may feel that, since they are responsible for the total care of a patient, this entitles them to reimbursement for every day that the patient is hospitalized, even though on certain days no identifiable service was rendered. Payment for medical care or medical management on this basis would be in conflict with Medicare coverage rules which state that "the physician must examine the patient in person or is able to visualize some aspect of the patient's condition without the interposition of a third person's judgement."

A rule of the hospital that the physician is required to visit patients daily is not considered a sufficient basis for the carrier to pay each daily visit. Acceptable documentation would be a physician's progress notes indicating the dates he visited the patient, or an entry in the physician's orders. In a teaching hospital setting, the medical record must contain signed or countersigned notes by the supervisory physician who is billing for the visits.

The Medicare carrier does not always check routinely for hospital record documentation. However, in cases where a complaint of nonrendition of services is received, the records of that physician will be reviewed. Payment may be denied if the review fails to show the necessary documentation, or, if the review is on a postpayment basis, a physician could be asked to refund a payment. *Proper documentation always provides proof of visits made* in case a patient raises a question with the Medicare carriers or his Social Security office regarding charges billed for visits.

## Changes in Participation and Certification of Laboratory Procedures

Notices were received from the Medicare Bureau of the following changes in participation and certification of tests and procedures of laboratories in the Medicare program:

**Approved for Participation:**

Cos Building Laboratory, 2500 Ridge Road, Evanston, Ill. 60201 (Provider Number 14-8355) has been approved for participation in the Medicare program, effective April 13, 1978. The laboratory is approved to perform the following tests and procedures: 130-Parasitology; 200-Serology; 310-Routine Chemistry; 320-Clinical Microscopy; 630-Diagnostic Cytology; 710-EKG Services.

**Changes in Approved Tests and Procedures:**

Island Medical Laboratory, Inc., 8452 Stony Island Ave., Chicago, Ill. 60617 (Provider Number 14-5247) has been approved to perform Procedure 630-Diagnostic Cytology, effective January 15, 1978. The laboratory is also approved to perform Procedure 110-Bacteriology; Procedure 200-Serology; Procedure 310-Chemistry Routine; Procedure 320 Clinical Microscopy; Procedure 400-Hematology; Procedure 510-Blood Group and Rh Typing.

Greenview Clinical Laboratories, Inc., 2752 West Fullerton Ave., Chicago, Ill. 60647 (Provider Number 14-8239) is no longer approved to perform Procedures 330-Chemistry-Other and 510-Blood Group and Rh Typing. The laboratory is approved to perform Proeedures 110-Bacteriology; 310-Chemistry Routine; 320-Clinical Microscopy; 200-Serology; 130-Parasitology; 510-Blood Group and Rh Typing; 710-EKG Services; 630-Diagnostic Cytology.

Ace Diagnostic Limited, 1411 West Irving Park Road, Chicago, Ill. 60613 (Provider Number 14-8293) is longer approved to perform Proeedures 130-Parasitology and 330-Chemistry-Other. The laboratory is approved to perform Procedures 110-Baeteriology; 200-Serology; 310-Chemistry Routine; 320-Clinieal Mieroscopy; 510-Blood Group and Rh Typing; 630-Diagnostic Cytology; 710-EKG Services; 400-Serology.

Lius Medical Laboratory, Inc., 1429 West Irving Park Road, Chicago, Ill. 60613 (Provider Number 14-8320) is no longer approved to perform Procedures 130-Parasitology; 330-Chemistry-Other and 510-Blood Group and Rh Typing. The laboratory is approved to perform Procedures 110-Baeteriology; 200-Serology; 310-Routine Chemistry; 320-Clinieal Microseopy and 630-Diagnostie Cytology.

St. Luke Family Health Center, Inc., 1414 South Indiana Ave., Chicago, Ill. 60605 (Provider Number 14-8343) is no longer approved to perform Proeedures 330-Chemistry-Other; 510-Blood Group and Rh Typing; 630-Diagnostic Cytology; and 710-EKG Services. The laboratory is approved to perform Procedures 110-Bacteriology; 130-Parasitology; 200-Serology; 310-Routine Chemistry; 320-Clinical Microscopy; and 400-Hematology.

*(This report is a service to the physicians of Illinois)*

IMJ
Illinois Medical Journal

OCTOBER, 1978 Vol. 154, No. 4 CONTENTS

## *Reference Issue*

203 ISMS Organization
205 Constitution and Bylaws
217 Policy Manual
231 House of Delegates
236 ISMS Councils and Committees
247 ISMS Services
254 Ancillary Organizations
263 Illinois State Government and Agencies
281 Medical Legal Information
286 Index to the Reference Section

## *Special Reports*

288 ISMS Legislative Update
304 Report of the Illinois AMA Delegation

## *Delegates' Handbook, 1978 Interim Session*

296 Delegates' Roster
299 County Medical Society Officers
307 Schedule of Meetings
309 Resolutions

## *Surgical Grand Rounds*

317 Case Report: Torsion of the Testis
*John M. Beal, M.D., Contributing Editor*

## *Rheumatology Rounds*

320 Acute Unilateral Ankle Swelling With Fever
*L. F. Layfer, M.D., and J. V. Jones, M.D., Contributing Co-Editors*

## *Clinical Articles*

324 Case Report: Phencyclidine Psychosis
*By Beverly J. Fauman, M.D., and Michael A. Fauman, M.D.*

## *President's Page*

313 Interim Session To Focus on Key Issues
*David S. Fox, M.D.*

*(Contents continued on overleaf)*

## Features


179 Clinics for Crippled Children
185 Viewbox
188 EKG of the Month
190 Obituaries
192 Guest Editorial
198 Pulse of the ISMS Auxiliary
200 ISMS Guide to Continuing Medical Education
311 Doctor's News
314 Physician Recruitment
322 Housestaff News
326 Classified Advertising


## Staff


**Managing Editor** ..... **Richard A. Ott**
**Assistant Editor** ..... **Mariann M. Stephens**
**Executive Administrator** ..... **Roger N. White**

*(Cover by Alicia Albanese Kolton)*

### PUBLICATIONS COMMITTEE

Herschel Browns, M.D., Chicago, *Chairman*
Kenneth A. Hurst, M.D., Naperville
Robert P. Johnson, M.D., Springfield
Alfred J. Kiessel, M.D., Decatur
Harold J. Lasky, M.D., Chicago

### Editorial Board

J. William Roddick, Jr., M.D., Springfield, *Chairman*
Eli L. Borkon, M.D., Carbondale
Daniel R. Cunningham, M.D., Wilmette
Raymond A. Dieter, Jr., M.D., Glen Ellyn
James G. Ekeberg, M.D., Palatine
Ediz Z. Ezdinli, M.D., Kenilworth
Carl Neuhoff, M.D., Peoria
Constantine S. Soter, M.D., Arlington Heights
Donald D. VanFossan, M.D., Springfield

Contributor in Surgery: John M. Beal, M.D., Chicago
Contributor in Maternal Death Studies:
Robert R. Hartman, M.D., Jacksonville
Contributor in Pediatric Perplexities: Ruth Andrea Seeler, M.D., Chicago
Contributor in Radiology: Leon Love, M.D., Maywood
Contributor in Cardiology: John R. Tobin, M.D., Maywood
Contributor in Immunopathology: Richard J. Ablin, Ph.D., Chicago
Contributor in Rheumatology: L. F. Layfer, M.D., Chicago

### ILLINOIS STATE MEDICAL SOCIETY

#### OFFICERS

David S. Fox, M.D., President
826 E. 61st St., Chicago 60637
P. John Seward, M.D., President-Elect
310 N. Wyman St., Rockford 61101
Herschel Browns, M.D., 1st Vice-President
4600 N. Ravenswood, Chicago 60640
G. W. Giebelhausen, M.D., 2nd Vice-President
1101 Main St., Peoria 61606
Audley F. Connor, Jr., M.D., Secretary-Treasurer
7531 S. Stony Island Ave., Chicago 60649

#### HOUSE OF DELEGATES

Cyril C. Wiggishoff, M.D., Speaker
25 E. Washington, Chicago 60602
Robert P. Johnson, M.D., Vice-Speaker
108 Maple Grove, Springfield 62707

#### TRUSTEES

1st District: 1980, John J. Ring, M.D.
511 Hawley, Mundelein 60060
2nd District: 1980, Allan L. Goslin, M.D.
712 N. Bloomington, Streator 61364
3rd District: 1979, Alfred Clementi, M.D.
675 W. Central Rd., Arlington Heights 60005
3rd District: 1980, Raymond J. Des Rosiers, M.D.
1044 N. Francisco, Chicago 60622
3rd District: 1979, Robert T. Fox, M.D.
2136 Robincrest, Glenview 60025
3rd District, 1979, Jere Freidheim, M.D.
3050 S. Wallace, Chicago 60616
3rd District: 1981, Morris T. Friedell, M.D.
7531 S. Stony Island Ave., Chicago 60649
3rd District: 1981, Henrietta Herholsheimer, M.D.
1700 E. 56th St., Chicago 60637
3rd District: 1981, Lawrence L. Hirsch, M.D.
2434 Grace St., Chicago 60618
3rd District: 1980, Harold J. Lasky, M.D.
55 E. Washington, Chicago 60602
3rd District: 1980, Richard N. Rovner, M.D.
645 N. Michigan, Suite 920, Chicago 60611
3rd District: 1980, Joseph C. Sherrick, M.D.
303 E. Superior, Chicago 60611
4th District: 1979, Fred Z. White, M.D.
723 N. Second St., Chillicothe 61523
5th District: 1979, P. F. Mahon, M.D.
800 E. Carpenter, Springfield 62702
6th District: 1981, Robert R. Hartman, M.D.
1515 A. W. Walnut, Jacksonville 62650
7th District: 1979, Alfred J. Kiessel, M.D.
1 Powers Lane Pl., Decatur 62522
8th District: 1979, James Laidlaw, M.D.
104 W. Clark, Champaign 61820
9th District: 1981, Warren D. Tuttle, M.D.
203 N. Vine St., Harrisburg 62946
10th District: 1981, Julian W. Buser, M.D.
6600 W. Main St., Belleville 62223
11th District: 1980, Kenneth A. Hurst, M.D.
52 Bunting Lane, Naperville 60540
12th District: 1980, Joseph Perez, M.D.
5670 E. State St., Rockford 61108
Trustee-At-Large: George T. Wilkins, M.D.
27 Glen Echo Dr., Edwardsville 62025
Chairman of the Board: Robert R. Hartman, M.D.
1515 A. W. Walnut, Jacksonville 62650



Microfilm copies of current as well as some back issues of the *Illinois Medical Journal* may he purchased from Xerox University Microfilm, 300 North Zeeb Road, Ann Arbor, Mich. 48106.

Contents of *IMJ* are listed in the *Current Contents/Clinical Practice.*

Published by the Illinois State Medical Society, 55 E. Monroe St., Chicago, Ill. 60603 (312-782-1654)



Copyright, 1978. The Illinois State Medical Society. All material subject to this copyright may he photocopied for the noncommercial purpose of scientific or educational advancement.



Suhscription $8.00 per year, in advance, postage prepaid, for the United States, Cuba, Puerto Rico, Philippine Islands and Mexico. $10.00 per year for all foreign countries included in the Universal Postal Union. Canada $8.50. U.S. Single current copies available at $1.00 ($1.10 by mail), back issues $1.50.

Second class postage paid at Chicago, Ill. When moving please notify Journal office of new address including old mailing label with notification, if possihle. POSTMASTER: Send notice on form No. 3579 to Illinois State Medical Society, 55 E. Monroe St., Chicago, Ill. 60603.

Pharmaceutical advertising must be approved by the ISMS Puhlications Committee. Other advertising accepted after review by Puhlications Committee or Board of Trustees. All copy or plates must reach the Journal office by the fifteenth of the month preceding publication. Rates furnished upon request.

Original articles will be considered for puhlication with the understanding that they are contributed only to the *Illinois Medical Journal.* The ISMS denies responsihility for opinions and statements expressed by authors or in excerpts, other than editorial or allied views or statements which reflect the authoritative action of the ISMS or of reports on official actions, policies or positions. Views expressed by authors do not necessarily represent those of the Society; any connection with official policies is coincidental.

The *Illinois Medical Journal* is published hy the Illinois State Medical Society as an educational and professional informational magazine and distributed as a benefit of membership in the Illinois State Medical Society. Its intent is to keep members current in medical knowledge and is a part of a continuing medical education program. Socioeconomic matters, affecting as they do a changing pattern in the proper delivery of medical care, are considered an inherent element in medical education.

# Clinics for Crippled Children Listed for November

Thirty-four clinics for Illinois' physically handicapped children have been scheduled for November by the University of Illinois, Division of Services for Crippled Children. The Division will count twenty-four general clinics providing diagnostic orthopedic, pediatric, speech and hearing examination, along with medical, social and nursing services. There will be nine special clinics for children with cardiac conditions and two for children with cerebral palsy. Any private physician may refer to or bring to a convenient clinic any child or children for whom he may want examination or consultative services.

November 1 Hinsdale—Hinsdale Sanitarium
November 1 Mt. Vernon—Good Samaritan Hospital
November 2 Effingham—St. Anthony Memorial Hospital
November 2 Pittsfield—Illini Community Hospital
November 2 Sterling—Community General Hospital
November 2 Lake County Cardiac—Victory Memorial Hospital
November 3 Division Cardiac—U. of I. at the Medical Center
November 7 Park Ridge Cardiac—Lutheran General Hospital
November 8 Champaign—McKinley Hospital
November 8 Joliet—St. Joseph's Hospital
November 8 Chicago Heights Gen.—St. James Hospital
November 9 DuQuoin—Marshall Browning Hospital
November 9 Springfield—St. John's Hospital
November 9 Macomb—McDonough District Hospital
November 10 Chicago Heights Cardiac—St. James Hospital
November 13 Peoria Cardiac—St. Francis Hospital
November 14 Peoria—St. Francis Hospital
November 14 East St. Louis—Christian Welfare Hospital
November 15 Centralia—St. Mary's Hospital
November 15 Rockford—St. Anthony's Hospital
November 15 Springfield Ped-Neuro—St. John's Hospital
November 15 Elgin—Sherman Hospital
November 15 Evergreen Park—Little Company of Mary Hospital
November 15 Chicago Heights Gen.—St. James Hospital
November 16 Elmhurst Cardiac—Memorial Hospital of DuPage County
November 17 Chicago Heights Cardiac—St. James Hospital
November 17 Kankakee Cardiac—St. Mary's Hospital
November 20 Maywood—Loyola Medical Center
November 21 Rock Island—Moline Public Hospital
November 21 Decatur—Decatur Memorial Hospital
November 21 Belleville—St. Elizabeth's Hospital
November 27 Peoria Cardiac—St. Francis Hospital
November 28 Peoria—St. Francis Hospital
November 28 Alton—Alton Memorial Hospital

The Division of Services for Crippled Children is the official state agency established to provide medical, surgical, corrective and other services and facilities for diagnosis, hospitalization and after-care for children with crippling conditions or who are suffering from conditions that may lead to crippling. In carrying on its program, the Division works cooperatively with local medical societies, hospitals, the Illinois Children's Hospital-School, civic and fraternal clubs, visiting nurse associations, local social and welfare agencies, local chapters of the National Foundation and other interested groups. In all cases, the work of the Division is intended to extend and supplement, not supplant, activities of other agencies, either public or private, state or local, carried on in behalf of crippled children.


# Librax®

Each capsule contains 5 mg
chlordiazepoxide HCl and 2.5 mg clidinium Br.

**Please consult complete prescribing information, a summary of which follows:**

**Indications:** Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

"Possibly" effective: as adjunctive therapy in the treatment of peptic ulcer and in the treatment of the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.

Final classification of the less-than-effective indications requires further investigation.

**Contraindications:** Glaucoma; prostatic hypertrophy, benign bladder neck obstruction; hypersensitivity to chlordiazepoxide HCl and/or clidinium Br.

**Warnings:** Caution patients about possible combined effects with alcohol and other CNS depressants, and against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Physical and psychological dependence rarely reported on recommended doses, but use caution in administering Librium® (chlordiazepoxide HCl) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions) reported following discontinuation of the drug.

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy. Advise patients to discuss therapy if they intend to or do become pregnant.**

As with all anticholinergics, inhibition of lactation may occur.

**Precautions:** In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship not established.

**Adverse Reactions:** No side effects or manifestations not seen with either compound alone reported with Librax. When chlordiazepoxide HCl is used alone, drowsiness, ataxia, confusion may occur, especially in elderly and debilitated; avoidable in most cases by proper dosage adjustment, but also occasionally observed at lower dosage ranges. Syncope reported in a few instances. Also encountered: isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent, generally controlled with dosage reduction; changes in EEG patterns may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice, hepatic dysfunction reported occasionally with chlordiazepoxide HCl, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax typical of anticholinergic agents, *i.e.*, dryness of mouth, blurring of vision, urinary hesitancy, constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.

ROCHE Roche Products Inc.
Manati, Puerto Rico 00701



## In treating certain G.I. disorders...

# Enhance your therapeutic expectations with the triple benefits of

Adjunctive

# Librax®

Each capsule contains 5 mg chlordiazepoxide HCl and 2.5 mg clidinium Br.

## antianxiety/antisecretory/antispasmodic

Librax is unique among G.I. medications in providing the specific antianxiety action of LIBRIUM® (chlordiazepoxide HCl) as well as the potent antisecretory and antispasmodic actions of QUARZAN® (clidinium Br) for adjunctive therapy of irritable bowel syndrome* and duodenal ulcer.*

ROCHE

*Librax has been evaluated as possibly effective for this indication.
Please see brief summary of prescribing information on preceding page.



# 20 days to shape his world

Your diagnosis is firm: Primary Hypertension.*

His future is in your hands now. The next 20 days are decisive.

What are the odds against that future? The sad fact is, half of America's hypertensives drop out of treatment.[1]

*You can improve those odds.* We can help you. Here's how:

**1.** COUNSEL: Talk to your patient about the disease and its consequences—about the problem of strokes, heart attacks, and kidney failure. Emphasize the need for taking the medication you've chosen, daily, and for the rest of your patient's life. Teach your patient about the drugs you prescribe—their effects and side effects. The more he knows, the more he'll be involved.

**2.** CATAPRES® (clonidine hydrochloride): because the data show that people stay with it. It has a high adherence rate.[2] There are good and substantial reasons why patients stay with Catapres—read them on the next pages.

Counsel...and Catapres. They can help change the odds against your patient's future. And to change them even more, ask us for these from your Boehringer representative:

—A major new film on Methods of Compliance
—A useful and extensive monograph on compliance
—The Onesti paper
—Patient Aid Booklet
—Patient worksheets
—Patient Reminder Postcards
—Other effective compliance enhancers

*By repeated determinations of the basal blood pressure,** and once the medical history, physical examination, including funduscopic and routine laboratory tests,† have been completed, one is usually able to exclude secondary causes and to be reasonably comfortable with a diagnosis of primary or essential hypertension.

**The National Hypertension Program Study Committee, in September, 1972, recommended blood pressures exceeding 140/90 mm Hg be regarded as excessive for adult Americans under age 50. The World Health Committee ceiling has been 160/95 mm Hg.

†Hematocrit, urinalysis, creatinine (or urea nitrogen), triglycerides, cholesterol, uric acid, plasma glucose, serum potassium, electrocardiogram, and chest x-ray.

Please see brief summary of prescribing information on last page of advertisement for warnings, precautions, and adverse reactions.






Tablets of 0.1 and 0.2 mg

# Catapres® (clonidine HCl) can help you shape his world

For most hypertensives, you need only two drugs... a diuretic and Catapres.

Start with either, depending on your judgment.

## If you've come to expect only this much of Catapres...

1. smooth lowering of blood pressure
2. effective for all degrees of hypertension (mild to moderate in potency)
3. brain, heart, and kidney blood flow preserved

## Ask for more of Catapres®

1. no contraindications
2. low incidence of depression and orthostatic hypotension
3. normal hemodynamics
4. no fatal hepatotoxicity
5. excellent record of compliance

**Most common side effects are dry mouth, drowsiness, and sedation, which generally tend to diminish with time.**

Please see brief summary of prescribing information on last page of advertisement for warnings, precautions, and adverse reactions.

Tablets of 0.1 and 0.2 mg

# Catapres®
# (clonidine HCl)

**It gives you more than you expect of Catapres**




Tablets of 0.1 and 0.2 mg

# Catapres® (clonidine HCl) can help you shape his world

Counsel...and Catapres. They can help change the odds against your patient's future. And to change them even more, ask us for these from your Boehringer representative:

—A major new film on Methods of Compliance
—A useful and extensive monograph on compliance
—The Onesti paper
—Patient Aid Booklet
—Patient worksheets
—Patient Reminder Postcards
—Other effective compliance enhancers

**References:**
1. Wilber JA, Barrow JS: Am J Med, *52*:653-663, 1972.
2. Data on file at Boehringer Ingelheim Ltd.

Boehringer Ingelheim

Boehringer Ingelheim Ltd
Ridgefield, CT 06877

**Catapres® brand of clonidine hydrochloride**
Tablets of 0.1 mg and 0.2 mg

**Indication:** The drug is indicated in the treatment of hypertension. As an antihypertensive drug, Catapres (clonidine hydrochloride) is mild to moderate in potency. It may be employed in a general treatment program with a diuretic and/or other antihypertensive agents as needed for proper patient response.

**Warnings:** Tolerance may develop in some patients necessitating a reevaluation of therapy.
*Usage in Pregnancy:* In view of embryotoxic findings in animals, and since information on possible adverse effects in pregnant women is limited to uncontrolled clinical data, the drug is not recommended in women who are or may become pregnant unless the potential benefits outweigh the potential risk to mother and fetus.
*Usage in Children:* No clinical experience is available with the use of Catapres (clonidine hydrochloride) in children.

**Precautions:** When discontinuing Catapres (clonidine hydrochloride), reduce the dose gradually over 2 to 4 days to avoid a possible rapid rise in blood pressure and associated subjective symptoms such as nervousness, agitation, and headache. Patients should be instructed not to discontinue therapy without consulting their physician. Rare instances of hypertensive encephalopathy and death have been recorded after cessation of clonidine hydrochloride therapy. A causal relationship has not been established in these cases. It has been demonstrated that an excessive rise in blood pressure, should it occur, can be reversed by resumption of clonidine hydrochloride therapy or by intravenous phentolamine. Patients who engage in potentially hazardous activities, such as operating machinery or driving, should be advised of the sedative effect. This drug may enhance the CNS-depressive effects of alcohol, barbiturates and other sedatives. Like any other agent lowering blood pressure, clonidine hydrochloride should be used with caution in patients with severe coronary insufficiency, recent myocardial infarction, cerebrovascular disease or chronic renal failure.

As an integral part of their overall long-term care, patients treated with Catapres (clonidine hydrochloride) should receive periodic eye examinations. While, except for some dryness of the eyes, no drug-related abnormal ophthalmologic findings have been recorded with Catapres (clonidine hydrochloride), in several studies the drug produced a dose-dependent increase in the incidence and severity of spontaneously occurring retinal degeneration in albino rats treated for 6 months or longer.

**Adverse Reactions:** The most common reactions are dry mouth, drowsiness and sedation. Constipation, dizziness, headache, and fatigue have been reported. Generally these effects tend to diminish with continued therapy. The following reactions have been associated with the drug, some of them rarely. (In some instances an exact causal relationship has not been established.) These include: Anorexia, malaise, nausea, vomiting, parotid pain, mild transient abnormalities in liver function tests; one report of possible drug-induced hepatitis without icterus and hyperbilirubinemia in a patient receiving clonidine hydrochloride, chlorthalidone and papaverine hydrochloride. Weight gain, transient elevation of blood glucose, or serum creatine phosphokinase; congestive heart failure, Raynaud's phenomenon; vivid dreams or nightmares, insomnia, other behavioral changes, nervousness, restlessness, anxiety and mental depression. Also rash, angioneurotic edema, hives, urticaria, thinning of the hair, pruritus not associated with a rash, impotence, urinary retention, increased sensitivity to alcohol, dryness, itching or burning of the eyes, dryness of the nasal mucosa, pallor, gynecomastia, weakly positive Coombs' test, asymptomatic electrocardiographic abnormalities manifested as Wenckebach period or ventricular trigeminy.

**Overdosage:** Profound hypotension, weakness, somnolence, diminished or absent reflexes and vomiting followed the accidental ingestion of Catapres (clonidine hydrochloride) by several children from 19 months to 5 years of age. Gastric lavage and administration of an analeptic and vasopressor led to complete recovery within 24 hours. Tolazoline in intravenous doses of 10 mg at 30-minute intervals usually abolishes all effects of Catapres (clonidine hydrochloride) overdosage.

**How Supplied:** Catapres, brand of clonidine hydrochloride, is available as 0.1 mg (tan) and 0.2 mg (orange) oval, single-scored tablets in bottles of 100 and 1000.

For complete details, please see full prescribing information.

Under license from Boehringer Ingelheim GmbH

Distributed by
Boehringer Ingelheim Ltd.
Ridgefield, CT 06877



# the view box

LEON LOVE, M.D./CHAIRMAN/DEPARTMENT OF RADIOLOGY
LOYOLA UNIVERSITY STRITCH SCHOOL OF MEDICINE

*This month's case report was contributed by Michael Fine, M.D., an assistant professor of radiology and Enrique Palacios, M.D., a professor of radiology, affiliated with the Loyola University Medical Center.*

*This 8-year-old male presented to the Emergency Room with a history of head trauma following a seizure. A frontal and lateral skull x-ray were obtained.*

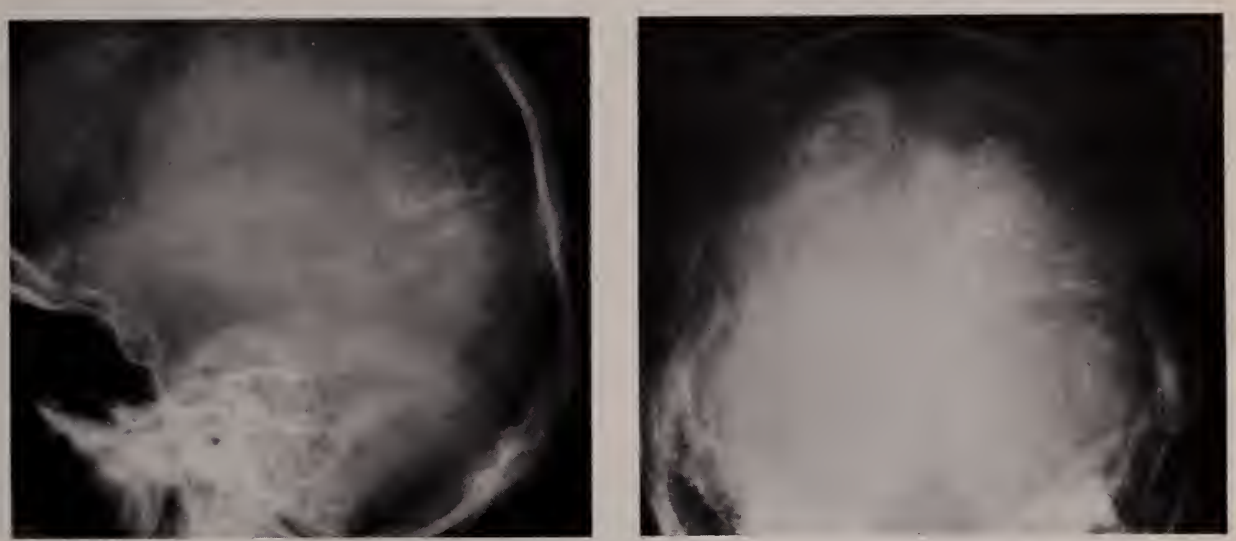


**Figure 1**

## *What's Your Diagnosis?*

The findings are consistent with:

(A) Calcified tumor
(B) Post-inflammatory calcifications
(C) Sturge-Weber syndrome
(D) Radio-opaque material in the hair

*(Continued on page 323)*




Copyright ©1978, Schering Corporation. All rights reserved.

Schering

## A unique clinical option... from Schering allergy research

# Optimine® 1 mg. tablets

brand of

# azatadine maleate

## Long-acting antihistamine relief

B.I.D.dosage provides sustained symptomatic relief for up to 24 hours. Helps to keep patients adequately controlled

Prolonged duration of antihistamine action is inherent in the molecular structure...not due to tablet coatings or other slow release processes

## B.I.D. effectiveness

Patients can fit OPTIMINE into morning and evening routines...no need to carry medication. The easy-to-titrate, scored 1 mg. tablet permits dosage flexibility to meet individual patient requirements

## No dyes

Contains no sensitizing dyes with their potential for causing allergic reactions

**Optimine** A practical antihistamine to help allergy patients stay on therapy

**CONTRAINDICATIONS** Use in Newborn or Premature infants: This drug should not be used in newborn or premature infants.

Use in Nursing Mothers: Because of the higher risk of antihistamines for infants generally and for newborns and prematures in particular, antihistamine therapy is contraindicated in nursing mothers.

Use in Lower Respiratory Disease: Antihistamines should NOT be used to treat lower respiratory tract symptoms including asthma

Antihistamines are also contraindicated in the following conditions: hypersensitivity to azatadine maleate and other antihistamines of similar chemical structure, monoamine oxidase inhibitor therapy (See DRUG INTERACTIONS Section).

**WARNINGS** Antihistamines should be used with considerable caution in patients with: narrow angle glaucoma, stenosing peptic ulcer, pyloroduodenal obstruction; symptomatic prostatic hypertrophy; bladder neck obstruction.

Use in Children: In infants and children especially, antihistamines in overdosage may cause hallucinations, convulsions, or death.

As in adults, antihistamines may diminish mental alertness in children. In the young child, particularly, they may produce excitation.

OPTIMINE TABLETS ARE NOT INTENDED FOR USE IN CHILDREN UNDER 12 YEARS OF AGE.

Use in Pregnancy: Experience with this drug in pregnant women is inadequate to determine whether there exists a potential for harm to the developing fetus.

Use with CNS Depressants: Azatadine maleate has additive effects with alcohol and other CNS depressants (hypnotics, sedatives, tranquilizers, etc.).

Use in Activities Requiring Mental Alertness: Patients should be warned about engaging in activities requiring mental alertness, such as driving a car or operating appliances, machinery, etc.

Use in the Elderly (approximately 60 years or older): Antihistamines are more likely to cause dizziness, sedation, and hypotension in elderly patients.

**PRECAUTIONS** Azatadine maleate has an atropine-like action and, therefore, should be used with caution in patients with: a history of bronchial asthma; increased intraocular pressure; hyperthyroidism; cardiovascular disease; hypertension.

**DRUG INTERACTIONS** MAO inhibitors prolong and intensify the anticholinergic (drying) effects of antihistamines

**ADVERSE REACTIONS** The most frequent adverse reactions are underlined

*General:* Urticaria, drug rash, anaphylactic shock, photosensitivity, excessive perspiration, chills, dryness of mouth, nose, and throat.

*Cardiovascular System:* Hypotension, headache, palpitations, tachycardia, extrasystoles.

*Hematologic System:* Hemolytic anemia, thrombocytopenia, agranulocytosis.

*Nervous System:* Sedation, sleepiness, dizziness, disturbed coordination, fatigue, confusion, restlessness, excitation, nervousness, tremor, irritability, insomnia, euphoria, paresthesias, blurred vision, diplopia, vertigo, tinnitus, acute labyrinthitis, hysteria, neuritis, convulsions

*Gastrointestinal System:* Epigastric distress, anorexia, nausea, vomiting, diarrhea, constipation.

*Genitourinary System:* Urinary frequency, difficult urination, urinary retention, early menses.

*Respiratory System:* Thickening of bronchial secretions, tightness of chest and wheezing, nasal stuffiness

**OVERDOSAGE** Antihistamine overdosage reactions may vary from central nervous system depression to stimulation. Stimulation is particularly likely in children. Atropine-like signs and symptoms (dry mouth; fixed, dilated pupils; flushing; and gastrointestinal symptoms) may also occur.

If vomiting has not occurred spontaneously, the patient should be induced to vomit. This is best done by having him drink a glass of water or milk after which he should be made to gag Precautions against aspiration must be taken, especially in infants and children.

If vomiting is unsuccessful, gastric lavage is indicated within three hours after ingestion and even later if large amounts of milk or cream were given beforehand Isotonic and ½ isotonic saline is the lavage solution of choice.

Saline cathartics, such as milk of magnesia, draw water into the bowel by osmosis and therefore are valuable for their action in rapid dilution of bowel content.

Stimulants should not be used.

Vasopressors may be used to treat hypotension.

FEBRUARY 1977 11055010

For more complete details, consult package insert or Schering literature available from your Schering Representative of Professional Services Department, Schering Corporation, Kenilworth, New Jersey 07033.

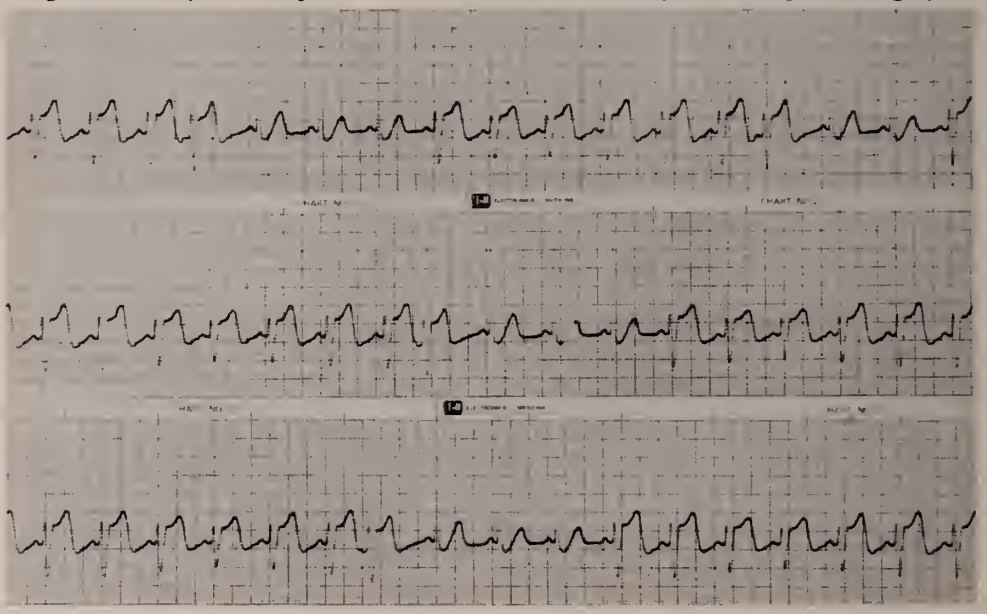
Schering Schering Corporation Kenilworth, New Jersey 07033

8202-0000 R

# ekg of the month

John F. Moran, M.S., M.D., David J. Hale, M.D.,
Patrick J. Scanlon, M.D., Sarah A. Johnson, M.D.,
John R. Tobin, M.S., M.D., and Rolf M. Gunnar, M.S., M.D.
Section of Cardiology, Department of Medicine,
Loyola University Stritch School of Medicine

*This is a 60-year-old man who came to the office complaining of worsening shortness of breath over the past six months. This progressed and was followed by paroxysmal nocturnal dyspnea and orthopnea. Past medical history was significant for inferior wall myocardial infarction eight years earlier. Physical examination demonstrated a grade 4/6 holosystolic murmur at the apex followed by a loud ventricular gallow ($S_3$). Cardiac catheterization demonstrated moderate pulmonary hypertension 50/20 with an elevated pulmonary capillary wedge pressure. The left ventricular angiogram showed severe mitral valvular regurgitation with an enlarged left atrium. The pulmonary veins were also visualized. Rupture of the papillary muscles of the mitral valve was suspected. Coronary arteriogram showed a 100% right coronary artery obstruction with few plaques in the left system. Open heart surgery with mitral valve replacement was performed. This long lead II rhythm strip was obtained on the first day following the surgery.*



## Questions:

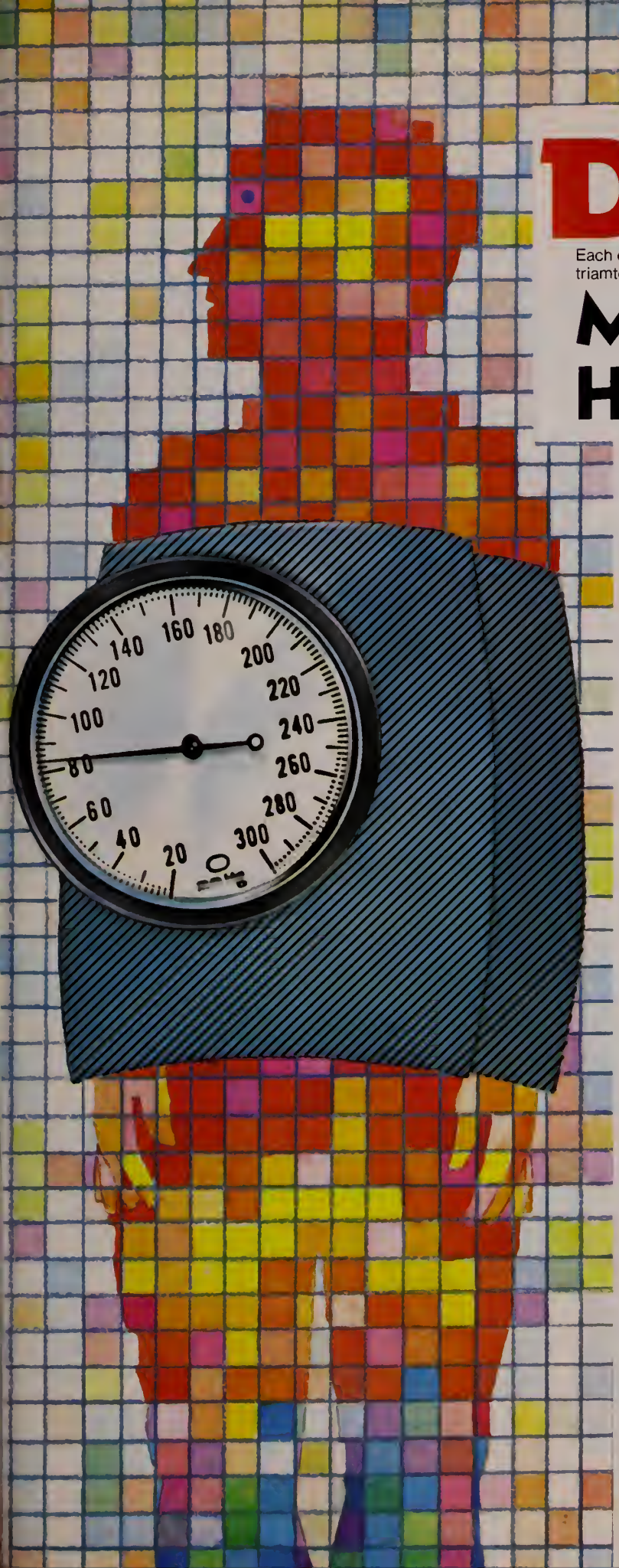
**1. The ECG shows:**

A. Premature atrial beats.
B. Paroxysmal junctional tachycardia.
C. Intermittent atypical complete left bundle branch block.
D. Cycle dependent left anterior hemiblock.
E. ST-T wave changes.

**2. Treatment should include:**

A. An increase in digitalis medication.
B. Quinidine 300 mg. every six hours orally.
C. Atropine 0.4 mg. intravenously.
D. Direct current cardioversion.
E. Temporary demand pacemaker as prophylaxis for sudden asystole.

*(Continued on page 328)*



# Dyazide®

Each capsule contains 50 mg. of Dyrenium* (brand of triamterene) and 25 mg. of hydrochlorothiazide.

# Makes Sense in Hypertension*

**Before prescribing, see complete prescribing information in SK&F Co. literature or *PDR*. A brief summary follows:**

* **Warning**
This drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual. If this combination represents the dosage so determined, its use may be more convenient in patient management. Treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant

**Contraindications:** Further use in anuria, progressive renal or hepatic dysfunction, hyperkalemia. Pre-existing elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs.

**Warnings: Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired.** If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in the severely ill, with urine volume less than one liter/day, the elderly and diabetics with suspected or confirmed renal insufficiency. Periodically, serum K+ levels should be determined. If hyperkalemia develops, substitute a thiazide alone, restrict K+ intake. **Associated widened QRS complex or arrhythmia requires prompt additional therapy.** Thiazides cross the placental barrier and appear in cord blood. Use in pregnancy requires weighing anticipated benefits against possible hazards, including fetal or neonatal jaundice, thrombocytopenia, other adverse reactions seen in adults. Thiazides appear and triamterene may appear in breast milk. If their use is essential, the patient should stop nursing. Adequate information on use in children is not available.

**Precautions:** Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Watch for signs of impending coma in severe liver disease. If spironolactone is used concomitantly, determine serum K+ frequently; both can cause K+ retention and elevated serum K+. Two deaths have been reported with such concomitant therapy (in one, recommended dosage was exceeded, in the other serum electrolytes were not properly monitored). Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with thiazides. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effect may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine.

**Adverse Reactions:** Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances. Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and, rarely, allergic pneumonitis have occurred with thiazides alone.

**Supplied:** Bottles of 100 and 1000 capsules; Single Unit Packages of 100 (intended for institutional use only).

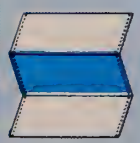
SK&F CO.
a SmithKline company
Carolina, P.R. 00630

Get PAID.

Time and time again, Medical Data Systems® users report: (1) substantial reductions in outstanding accounts receivable, (2) accelerated cash flow, (3) elimination of missing charges, and (4) faster turn around on third-party claims. Data processing services are more than fancy reports. MDS can be the difference between getting paid and not getting paid. And that's a good business basic.

S-Tek Computer Services — The Data Processing Tailors

MEDICAL DATA SYSTEMS®



Call or write our Sales Department for more information.

S-Tek
COMPUTER SERVICES, INC.
P.O. BOX 328 TERRE HAUTE, IN 47808 812-232-1385

Medical Data Systems,® a registered trademark of S-Tek Computer Services Inc.

# *Obituaries*

**°°Berard, LeRoy, H., Oak Park, died September 6, 1978, at the age of 80. He was a 1929 graduate of the Rush Medical College. During his medical career, Dr. Berard served on the staff of Cook County Hospital and the Chicago Tuberculosis Sanitarium.

**Brown, Cabot, San Francisco, died on September 17, 1978, at the age of 76. Dr. Brown was a former Chicagoan.

**°°Hardin, Parker C., Rockford, died August 25, 1978, at the age of 78. A 1927 graduate of Harvard, Dr. Hardin was a Diplomate with the American Board of Surgery and a Fellow of the American College of Surgeons.

**Hollander, Fredrerick G., California, died at the age of 67. Dr. Hollander was a former Chicago resident.

**°Janda, Rudolph W., La Grange Park, died September 5, 1978, at the age of 58. Dr. Janda was a 1944 graduate of the University of Chicago.

**°Kochenski, Richard V., Chicago, died on September 10, 1978. He was a 1935 graduate of the Chicago Medical School.

**°Lewis, Calvin I., Glencoe, died September 20, 1978 at the age of 63. Dr. Lewis graduated from the University of Illinois in 1941. He was affiliated with St. Therese Hospital in Waukegan.

**Lloyd, Donald, Elgin, died August 23, 1978, at the age of 61. He was a graduate of Northwestern Medical School. Dr. Lloyd was a past president of the Sherman Hospital Medical Staff.

**°Mizock, Albert, Chicago, died August 31, 1978, at the age of 72. Dr. Mizock was a 1934 graduate of the Chicago Medical School. During his years of practice, Dr. Mizock was on the staff of Walther Memorial and Central Community Hospitals.

**Oberschneider, Paul, Elgin, died August 9, 1978, at the age of 58.

**°°Richter, Oscar, Chicago, died September 6, 1978, at the age of 77. He was a 1927 graduate of the University of Chicago. Dr. Richter held staff positions on Belmont and St. Anne's Hospitals.

**°Schmidt, Richard H., Chicago, died September 10, 1978, at the age of 58. Prior to his death, Dr. Schmidt was a radiologist on the staff of Illinois Masonic Medical Center. Formerly a resident of Valparaiso, Indiana, he was director of radiology at Porter Memorial Hospital.

**Simunich, William A., Phoenix, Arizona, died August 10, 1978, at the age of 83. A former Chicagoan, Dr. Simunich served on the Staff of Mercy Hospital and the Lewis Memorial Maternity Center.

**Ziegler, Rudolph, Oregon, died in an accident on August 10, 1978 at the age of 61. A former Chicagoan, Dr. Ziegler was an official of the Fellows of International College of Physicians. He was a graduate of the Chicago Medical College.

*°Indicates ISMS member.*
*°°Indicates member of the ISMS Fifty Year Club.*

# Angina freedom fighter...




Wellcome

**Burroughs Wellcome Co.**
Research Triangle Park
North Carolina 27709

**Cardilate® (erythrityl tetranitrate)**
INDICATIONS: For the prophylaxis and long-term treatment of patients with frequent or recurrent anginal pain and reduced exercise tolerance associated with angina pectoris, rather than for the treatment of the acute attack of angina pectoris, since its onset is somewhat slower than that of nitroglycerin.

PRECAUTIONS: As with other effective nitrites, some fall in blood pressure may occur with large doses.

Caution should be observed in administering the drug to patients with a history of recent cerebral hemorrhage, because of the vasodilation which occurs in the area. Although therapy permits more normal activity, the patient should not be allowed to misinterpret freedom from anginal attacks as a signal to drop all restrictions.

SIDE EFFECTS: No serious side effects have been reported. In sublingual therapy, a tingling sensation (like that of nitroglycerin) may sometimes be noted at the point of tablet contact with the mucous membrane. If objectionable, this may be mitigated by placing the tablet in the buccal pouch. As with nitroglycerin or other effective nitrates, temporary vascular headache may occur during the first few days of therapy. This can be controlled by temporary dosage reduction in order to allow adjustments of the cerebral hemodynamics to the initial marked cerebral vasodilation. These headaches usually disappear within one week of continuous therapy but may be minimized by the administration of analgesics.

Mild gastrointestinal disturbances occur occasionally with larger doses and may be controlled by reducing the dose temporarily.

DOSAGE: Therapy may be initiated with 10 mg sublingually prior to each anticipated physical or emotional stress and at bedtime for patients subject to nocturnal attacks. The dose may be increased or decreased as needed.

HOW SUPPLIED: 10 mg chewable scored tablets, bottle of 100. Also 5, 10 and 15 mg oral/sublingual scored tablets in bottles of 100. 10 mg oral/ sublingual scored tablets also supplied in bottle of 1,000.

Also available: Cardilate®-P (Erythrityl Tetranitrate with Phenobarbital)* Tablets (Scored).

(*Warning—may be habit-forming.)

1. Taken sublingually, Cardilate® (erythrityl tetranitrate) begins to work within 5 minutes, eliminating or reducing frequency and severity of anginal pain for up to two hours.
2. Fear of pain, a major deterrent to achieving acceptable (and desirable) levels of activity, including sex, may be allayed with Cardilate. Effective prophylaxis and improved exercise tolerance help toward normalizing the lives of anginal patients.

# Cardilate®
## (erythrityl tetranitrate)

# Guest Editorial

## *Marketplace Choice as Deterrent To Government Price Controls*

*Editor's Note: The guest editorial below was submitted by the American Medical Association for your consideration with the following comment:*

*Alain G. Enthoven, the noted Stanford University ecomonist, recently told the AMA Board of Trustees, "We're on the track to an increasingly regulated system (of health-care delivery)."*

*He added, "The alternative to increasing government regulation is a system of incentives for economy and fair-market competition as recommended by your National Commission on the Cost of Medical Care."*

The AMA-created National Commission on the Cost of Medical Care has opened up a new horizon by emphasizing the need to restore the concept of free-marketplace choice in health-care delivery.

What does that mean?

Well, picture the delivery system as a marketplace where producers and consumers handle their transactions through insurers, private and public. The Cost Commission report recommends that producers and consumers have direct impact on decisions made in their behalf.

Consumers want to buy services at a lower annual rate of cost growth than the 11% it has averaged since 1966.

However, the marketplace right now is not functioning well. It was flexible in the days when consumers paid the producer directly. But the patterns of coverage offered by today's middleman insurers are largely standardized in benefits and therefore in costs.

The Cost Commission report suggests ways in which those patterns can be stimulated to offer a latitude and freedom of choice.

For instance, employees could choose among health-care plans in terms of premium price, whereas employer contributions to premiums would be the same for any plan. The employee selecting a plan less expensive than the employer contribution would either be reimbursed for the difference or receive additional benefits.

The report makes this general observation:

"Reliance on market mechanisms can lead to cost-effective production of output, and permit consumer preferences to play a key role in determining what goods and services are available."

Unfortunately, this leeway cannot control costs all by itself. Nor does the marketplace assure care to the poor and uninformed, and their health-care costs could continue to rise sharply.

Hence, there must be some reliance on provider self-regulation and on local regulation if the overall tab is to be kept in line. No federal controls are recommended by the report.

Self-regulation would include cost-containment initiatives in the private sector of care, among third-party payers, and in medical practice. Says the report:

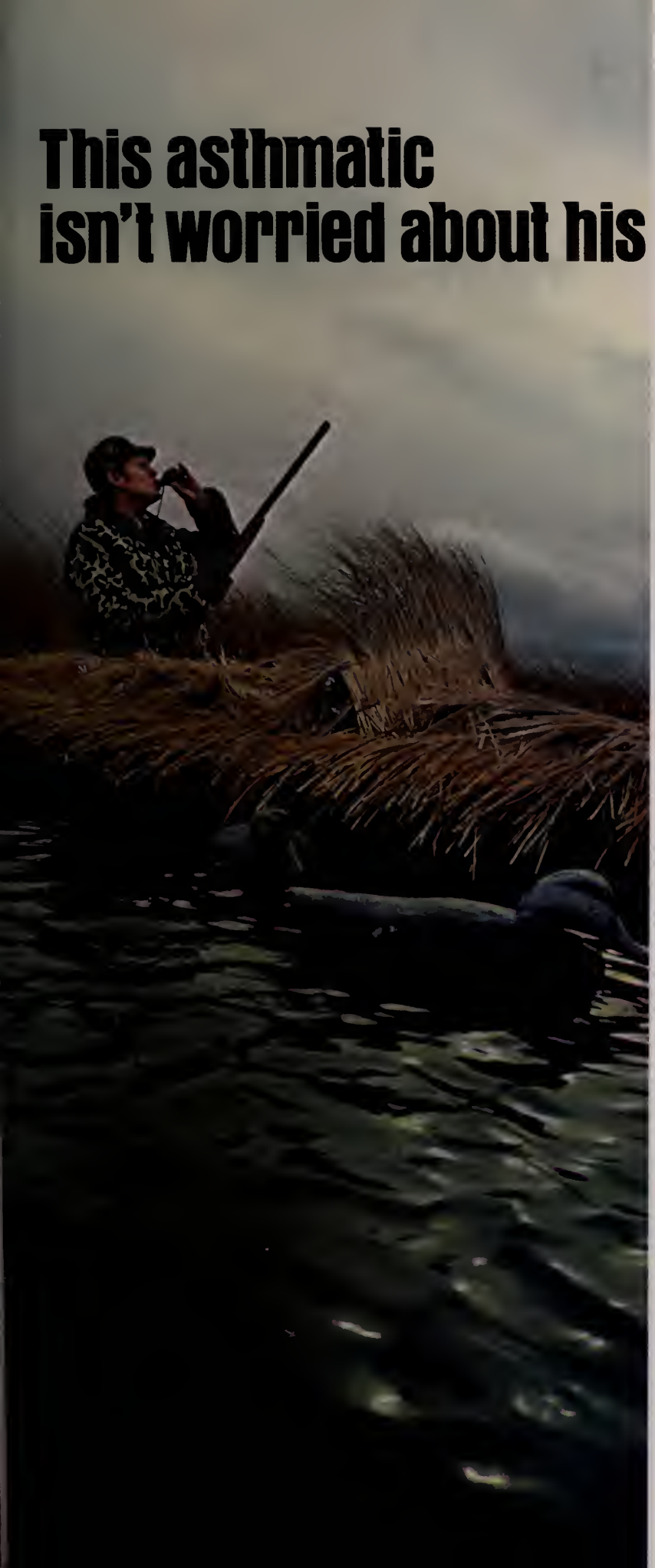
"In the past, providers have considered primarily the medical needs of their patients. The Commission believes that providers must now take steps to make cost-effective utilization recommendations without sacrificing the quality of care. There are a number of programs that can be undertaken within the health-care system that are not dependent on major changes in the delivery system."

The chief value of the report is that it brings many ideas and groups together in a coordinated program for genuine action. Some of the ideas are old but have never been implemented. Group responsibilities include those placed on the consumer.

The upshot could be a momentum that would head off arbitrary, unwieldy federal formulas for cost containment. Developed after a year and a half of intensive study and effort, the Cost Commission report presents credible alternatives to those formulas. ◄

**AMA**

# This asthmatic isn't worried about his next breath...



## he's active he's effectively maintained on

# QUIBRON®

Each capsule or tablespoon (15 ml) elixir contains theophylline (anhydrous) 150 mg and glyceryl guaiacolate (guaifenesin) 90 mg. Elixir: alcohol 15%

- theophylline for effective around-the-clock bronchodilator therapy
- 100% free theophylline

**Indications:** For the symptomatic relief of bronchospastic conditions such as bronchial asthma, chronic bronchitis, and pulmonary emphysema.

**Warnings:** Do not administer more frequently than every 6 hours, or within 12 hours after rectal dose of any preparation containing theophylline or aminophylline. Do not give other compounds containing xanthine derivatives concurrently.

**Precautions:** Use with caution in patients with cardiac disease, hepatic or renal impairment. Concurrent administration with certain antibiotics, i.e. clindamycin, erythromycin, troleandomycin, may result in higher serum levels of theophylline. Plasma prothrombin and factor V may increase, but any clinical effect is likely to be small. Metabolites of guaifenesin may contribute to increased urinary 5-hydroxyindoleacetic acid readings, when determined with nitrosonaphtol reagent. Safe use in pregnancy has not been established. Use in case of pregnancy only when clearly needed.

**Adverse Reactions:** Theophylline may exert some stimulating effect on the central nervous system. Its administration may cause local irritation of the gastric mucosa, with possible gastric discomfort, nausea, and vomiting. The frequency of adverse reactions is related to the serum theophylline level and is not usually a problem at serum theophylline levels below 20 $\mu$g/ml.

**How Supplied:** Capsules in bottles of 100 and 1000 and unit-dose packs of 100; Elixir in bottles of 1 pint and 1 gallon.

See package insert for complete prescribing information.

Mead Johnson PHARMACEUTICAL DIVISION

©1978 Mead Johnson & Company • Evansville, Indiana 47721 U.S.A. MJL 8-4294R

# The Great Laxative Escape



## COLACE®

dioctyl sodium sulfosuccinate

Colace means escape—from laxative stimulation, from laxative harshness, from laxative habit. Colace gently helps soften stools for easy, painless, unstrained elimination. It's the great laxative escape, from infancy to old age. Available in 100 and 50 mg. capsules. Syrup or liquid.

Mead Johnson

PHARMACEUTICAL DIVISION

©1978 Mead Johnson & Company • Evansville, Indiana 47721 U.S.A. J578-1

# AFRICAN ADVENTURE

Is Morocco and Kenya. Wander the narrow streets of the Casbahs in ancient Rabat and mysterious Casablanca. Shop in colorful souks. Visit Djemaa El Fna Square in Marrakech, teeming with storytellers, snake charmers and soothsayers. Roam the vast game parks of Kenya by safari rover. Capture elephant, zebra and lion on film. Relax at luxurious lodges or take a trip into Masai and Kikuyu native villages. Lounge on the sands of Mombasa and let the warm Indian Ocean soothe you. Discover enough native artifacts to start your own museum.



Join our two-week Adventure to the land that fascinated Hemingway — before it disappears forever. We depart **Chicago** on **February 27, 1979,** returning on **March 13, 1979.** Leave winter behind . . . escape to Africa.

**$1628.00**
includes chartered round-trip jet flights, deluxe hotel in each city, full American breakfast, and dinner each evening at a selection of the finest restaurants.

**Make Your African Adventure Reservations Today!**

Send to: Illinois State Medical Society
55 East Monroe, Chicago, Illinois 60603

Enclosed is my check for $_____($100 per person), as deposit.

Name _____

Home Address _____

City _____ State _____ Zip _____

Area Code _____ Phone _____

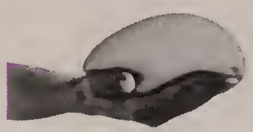
**A Non-Regimented INTRAV Deluxe Adventure**



# Yours Truly™ by Jobst® — it's only natural.

Finally, a truly natural external breast prosthesis is available to your patients. No need to follow the trauma of a radical mastectomy and associated psychological overlay with an ugly, even grotesque breast prosthesis of unnatural polyvinyl chloride.

Now, with the help of your nurse, Reach to Recovery volunteers, and others, you can suggest to your postmastectomy patients an external breast form that is seamless and natural. The Yours Truly™ breast form is new. Worn right against the skin it requires no special bra to stay in place. It moves with the vitality and flow of a natural breast. The silicone gel inside has a specific gravity of .98, only .04 more dense than human breast tissue and the response in vivo is nearly identical. There are thirteen sizes from which to choose, each with the contour and suppleness of the female breast size it replaces.



**Contact your local Jobst Service Center for complete details.**

**JOBST CHICAGO SERVICE CENTER**

**Chicago, Illinois 60602**
Suite 2101, Pittsfield Bldg.
55 E. Washington Street
312/346-0446

# A large number of business problems may really be communications problems.

# This number can help.




Many costly business problems can be communications problems.

But many can be economically solved by doing a little serious thinking about your communications system.

That's why we opened the Communications Planning Center. If you run your own business or a division of a larger corporation and feel like something is gnawing at your profits, give us a call at the number above. Toll-free.

Our professional Account Executives are specially trained to help you identify communications problems. Analyze them. And show you how they affect your profits.

Then they'll offer solutions based on the Bell System's state-of-the-art equipment for voice and data communications.

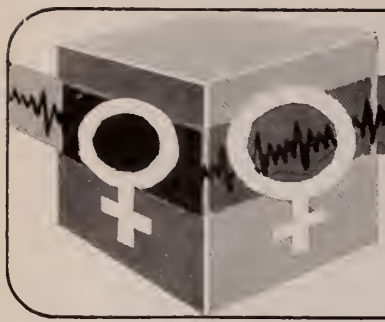
And backed up by Illinois Bell's professional service.

For some possible solutions to your office's problems, pick up the phone and call us. Or you can see some of these solutions when you visit us at 155 N. Wacker Drive, first floor. We're open Monday through Friday, 8:30 a.m. to 5 p.m.

The telephone number above could make a real difference in the numbers on your bottom line.

**The system is the solution.**

Illinois Bell



pulse... of the ISMS auxiliary

Mrs. Eugene Vickery, Editor



Mrs. Earl V. Klaren, President, ISMSA

## Growth Patterns

# Medical Marriage: Joys and Sorrows

*The American Medical Association Auxiliary Convention was held June 18-21 in St. Louis, Missouri. Those who attended have reported a valuable educational experience. The following piece is excerpted from the AMAA publication, "Facets," detailing one presentation from that meeting. It reports several interesting comments on medical marriage.*

A five-member panel, moderated by Peter A. Martin, M.D., clinical professor of psychiatry at Michigan and Wayne State University Medical Schools and member of the AMA Section Council on Psychiatry, examined the special stresses a medical career places on a marriage.

Mrs. Mary Glasgow, a physician's wife who is a poet and artist, presented a personal view of the medical marriage in a talk she humorously titled "On Being Married to God." "You can never escape his fan club," nor the "phonecalls at all hours," she said in noting the annoyances of the medical marriage. But, she said, these are balanced by special benefits. "There is a real pleasure in the role of 'Frau Doctor' or 'Frau Professor,'" she maintained. Because a medical career is so demanding of the physician's time and energy, the nonphysician member of a couple may feel cheated. But, said Mrs. Glasgow, if the spouse has a positive attitude, these problems can be overcome. "The woman who considers herself entitled to the good things in life" such as a fulfilling home life and a career, "seems to be the one who gets those things," she said.

Ellen M. Berman, M.D., Director, Division of Family Study, University of Pennsylvania, discussed the stages of adult development, explaining how these stages relate to the physician's time frame and how they can affect relationships. "Each decade asks us different things, and this affects our marriage greatly," she noted.

Stephanie Cavanaugh, M.D., assistant professor of psychiatry, Rush Medical School, Chicago, discussed the socialization process taking place in medical schools. Dr. Cavanaugh drew upon her professional experience as well as personal

experience with her physician-husband. "Medical school and residency training programs are still structured in such a way that time for a personal life is almost non-existent," she said.

That structure is slowly changing, she noted, adding that in the meantime, spouses should "build a solid support system of friends, family, neighbors, and household help." and have "gratifying activities and careers outside the home."

H. Waldo Bird, clinical professor of psychiatry at St. Louis University, provided an inside view of the marriage counseling therapy room. After detailing the warning signs of problems in a marriage, Dr. Bird offered an unbeat view of a marriage relationship. "There really is no more optimal situation for two people to learn who they are than in the framework of marriage," he said.

## *Special Note*

Fall Conference for the southern counties will be held Thursday, November 9, 1978, at the Belleville Ramada Inn. For further information about the exciting program, as well as reservations, please contact program co-chairmen Mrs. Thomas Meirink or Mrs. Andrew Gregowicz, both of Belleville.

## ISMS Travel Programs

The following ISMS-sponsored travel programs have been scheduled for 1979:

Feb. 27-Mar. 13—Africa (Morocco/Kenya)

June 24-July 5—Rhine Cruise (Munich, Rhine River, Brussels)

July 30-Aug. 12—European Adventure (Paris, Interlacken, Florence)

Sept. 2-15—Danube Cruise (Vienna to Istanbul)

Reservations cannot be accepted without the official form printed in promotional brochures, which will be mailed to all ISMS members and auxiliary at least five months in advance. Individuals outside a member's immediate family will be placed on standby status until all ISMS members have had reasonable time to make reservations. Promotional expenses connected with these programs are paid by tour operators. For further information, please contact ISMS headquarters.

★
*Specialized Service*
IN
PROFESSIONAL LIABILITY INSURANCE
*is a high mark of distinction*
Since 1899
THE
MEDICAL PROTECTIVE COMPANY
FORT WAYNE, INDIANA

CHICAGO AREA OFFICE:
T. J. Pandak, J. C. Kunches, L. R. Gannon, and W. G. Prangle, Representatives
814 Commerce Drive, Suite 109, Oak Brook, Illinois 60521 (312) 325-7314
SPRINGFIELD OFFICE: W. J. Nattermann, Representative
426½ South Fifth Street, Springfield 62701 (217) 544-2251

# ISMS Guide to Continuing Medical Education

Compiled for Illinois physicians by the
ILLINOIS COUNCIL ON CONTINUING MEDICAL EDUCATION
55 E. Monroe St., Suite 3510 • Chicago, IL 60603 • (312) 236-6110

*Items for this Calendar must be received 90 days prior to the event. Those received earlier may appear in up to three monthly issues.*

*WARNING! Items for this Calendar come from many sources, often far in advance of the publication date. Sometimes, cancellations or changes in date, place or time occur too late to be corrected before publication. You are urged to contact the sponsoring organization to confirm information given below.*

## NOVEMBER

### *Family Medicine*

**UPDATE—PRIMARY CARE MEDICINE**
**For:** GP's FP's, Internists. Lectures, Nov. 3 & 17, Chicago. **Sponsor:** Grant Hospital, 550 W. Webster, Chicago 60614. **Fee:** none. **Reg. limit:** 200. **CME Credit:** AMA Category 1, 2 hours. **Contact:** P. Colon. **Phone:** 312-883-2112.

### *Family Therapy*

**WORKING WITH FAMILIES IN A GENERAL MEDICAL PRACTICE**
**For:** MD's, medical health practitioners. Seminar series, Nov. '78-June '79, Oak Park. **Speakers:** James McCoy, MD, Charles Kramer, MD. **Sponsor:** Center for Family Studies/The Family Institute of Chicago, 10 E. Huron, Chicago 60611. **Cosponsors:** Institute of Psychiatry, Northwestern Memorial Hospital, Northwestern University Medical School. **Contact:** Jeanne Robinson. **Phone:** 312-649-7285.

### *Family Therapy*

**SEVENTH ANNUAL FALL CONFERENCE: CHANGING THE FAMILY BELIEF SYSTEM**
**For:** MD's. 2-day conference, Nov. 3-4, 9:30 a.m.-4:30 p.m., Chicago. **Speaker** Peggy Papp, ACSW. **Sponsor:** Center for Family Studies/The Family Institute of Chicago, 10 E. Huron, Chicago 60611. **Cosponsors:** Institute of Psychiatry, Northwestern Memorial Hospital, Northwestern University Medical School. **CME Credit:** AMA Category 1, 12 hours. **Contact:** Wendy Brockington. **Phone:** 312-649-7285.

### *Family Therapy*

**PARADOXICAL TECHNIQUES IN FAMILY THERAPY**
**For:** MD's. 1-day workshop, Nov. 16, Chicago. **Speaker:** Robert Mark, Ph.D. **Sponsor:** Center for Family Studies/The Family Institute of Chicago, 10 E. Huron, Chicago 60611. **Cosponsors:** Institute of Psychiatry, Northwestern Memorial Hospital, Northwestern University Medical School. **CME Credit:** AMA Category 1, 6 hours. **Contact:** Wendy Brockington. **Phone:** 312-649-7285.

### *Forensic Medicine*

**REVIEW OF CURRENT FORENSIC PATHOLOGY CASES**
**For:** MD's, DDS's, LIB's. Workshop/lecture, Thursdays, 2:00 p.m., Chicago. **Sponsor:** Office of the Medical Examiner, Cook County, Illinois, 1828 W. Polk St., Chicago 60612. **Fee:** none. **Reg. limit:** 50. **Contact:** Robert Stein, MD. **Phone:** 312-443-5017.

### *Infections and Antibiotics*

**UPDATE ON COMMON INFECTIONS AND ANTIBIOTICS**
**For:** Primary care physicians. Lecture, Nov. 29, Rockford. **Sponsor:** Dept. of Family Practice, Rockford School of Medicine, Office for Continuing Education, 1601 Parkview Ave., Rockford, IL 61101. **Fee:** $10. **Reg. limit:** none. **CME Credit:** AMA Category 1. **Contact:** Jacqueline Parochka. **Phone:** 815-987-7140.

### *Infectious Diseases*

**RECENT ADVANCES IN INFECTIOUS DISEASES**
**For:** MD's, residents, students. Lecture series, Nov. '78-May '79, Rockford. **Sponsors:** Division of Infectious Diseases, Rockford School of Medicine, Office for Continuing Education, 1601 Parkview Ave., Rockford, IL 61101. **Fee:** $25. **Reg. limit:** none. **CME Credit:** AMA Category 1, 18 hours. **Contact:** Jacqueline Parochka. **Phone:** 815-987-7140.

### *Internal Medicine*

**BLOOD GASES—ELECTROLYTE IMBALANCE—HYPERALIMENTATION**
**For:** MD's, office staff. Symposium, Nov. 14, 6:00-10:00 p.m., Highland. **Sponsor:** SIU School of Medicine, 801 No. Rutledge, P.O. Box 3926, Springfield, IL 62708. **Fee:** $25 pre. **Reg. limit:** none. **CME Credit:** AMA Category 1, 4 hours. **Contact:** Lorraine Stephenson. **Phone:** 217-782-7711.

### *Medical/Legal*

**23rd MEDICAL/LEGAL SEMINAR FOR LAKE COUNTY**
**For:** MD's, DDS's, nurses, pharmacists, pharmaceutical representatives, ancillary medical personnel. 1-day seminar, Nov. 15, Waukegan. **Sponsor:** St. Therese Hospital, 2615 Washington, Waukegan, IL 60085. **Reg. deadline:** 11/13. **Fee:** $2.50. **Reg. limit:** none. **CME Credit:** AMA Category 1, 5 hours; AAFP Elective, 5 hours; AOA, 5 hours. **Contact:** R. M. Adelman, DDS, MD, JD. **Phone:** 312-688-5800.

### *Medicine*

**CARDIOLOGY CONFERENCE**
**For:** open. Case presentations, Saturdays, 8:00 a.m., Nov. '78-June '79, Evanston. **Sponsor:** St. Francis Hospital, 355 Ridge Ave., Evanston, IL 60202. **Fee:** none. **Reg. limit:** none. **Contact:** Mitchel Byrne, MD. **Phone:** 312-492-6227.

### *Medicine*

**NEWER ANTIBIOTICS FOR GRAM-NEGATIVE INFECTIONS**
**For:** MD's, interns. Lecture, Nov. 22, 11:00 a.m., Chicago. **Speaker:** Mary Carruthers, MD. **Sponsor:** Martha Washington Hospital, 4055 No. Western Ave., Chicago 60618. **Fee:** none. **Reg. limit:** none. **CME Credit:** AMA Category 1, 1 hour; AAFP Elective, 1 hour. **Contact:** Fernando Villa, MD. **Phone:** 312-583-9000 x 331.

### *Medicine*

**NEUROLOGY CONFERENCE**
**For:** open. Lecture series, Nov. '78-June '79, 2nd/4th Tuesday, Evanston. **Speaker:** M. M. Ilahi, MD. **Sponsor:** St. Francis Hospital, 355 Ridge Ave., Evanston, IL 60202. **Reg. limit:** none. **Fee:** none. **Contact:** Mitchel Byrne, MD. **Phone:** 312-492-6227.

### *Medicine*

**NEPHROLOGY**
**For:** open. Lecture series, Nov. '78-June '79, 2nd/4th Wednesday, Evanston. **Sponsor:** St. Francis Hospital, 355 Ridge Ave., Evanston, IL 60202. **Fee:** none. **Reg. limit:** none. **Contact:** Mitchel Byrne, MD. **Phone:** 312-492-6227.

### *Medicine*

**PULMONARY DISEASES CONFERENCE**
**For:** open. Lecture series, Nov. '78-June '79, 1st/3rd Tuesdays, Evanston. **Speaker:** M. J. Kim, MD. **Sponsor:** St. Francis Hospital, 355 Ridge Ave., Evanston, IL 60202. **Reg. limit:** none. **Contact:** Mitchel Byrne, MD. **Phone:** 312-492-6227.

### *Medicine*

**RESPIRATORY DISEASE**
**For:** MD's, office staff. Symposium, Nov. 30, 1:00-5:00 p.m., Jacksonville. **Sponsor:** SIU School of Medicine, 801 No. Rutledge, P.O. Box 3926, Springfield, IL 62708. **Fee:** $25 pre. **CME Credit:** AMA Category 1, 4 hours. **Contact:** Lorraine Stephenson. **Phone:** 217-782-7711.

### *Medicine*

**CHRONIC OBSTRUCTIVE PULMONARY DISEASE**
**For:** MD's, office staff. Symposium, Nov. 8, 1:00-5:00 p.m., Herrin. **Sponsor:** SIU School of Medicine, 801 No. Rutledge, P.O. Box 3926, Springfield, IL 62708. **Fee:** $25 pre. **Reg. limit:** none. **CME Credit:** AMA Category 1, 4 hours. **Contact:** Lorraine Stephenson. **Phone:** 217-782-7711.

### *Medicine*

**GI CONFERENCE**
**For:** open. Lecture series, Nov. '78-March '79, Saturdays, Evanston. **Speaker:** Fernando Villa, MD. **Sponsor:** St. Francis Hospital, 355 Ridge Ave., Evanston, IL 60202. **Fee:** none. **Reg. limit:** none. **Contact:** Mitchel Byrne, MD. **Phone:** 312-492-6227.

### *Medicine*

**BI-WEEKLY CLINICAL CONFERENCE**
**For:** MD's, DDS's. Seminar Series, Thursdays, 8:00 a.m., Nov. '78-May '79, Mattoon. **Sponsor:** Sarah Bush Lincoln Health Center, Route 16, Mattoon, IL 61938. **Fee:** none. **CME Credit:** AMA Category 1. **Contact:** Byron Ruskin, MD. **Phone:** 217-258-2514.

### *Medicine*

**GI CONFERENCE**
**For:** open. Lecture series, Nov. '78-June '79, Thursdays, 3:00 p.m., Evanston. **Speaker:** David Johnson, MD. **Sponsor:** St. Francis Hospital, 355 Ridge Ave., Evanston, IL 60202. **Fee:** none. **Reg. limit:** none. **Contact:** Mitchel Byrne, MD. **Phone:** 312-492-6227.

### *Antibiotic Therapy—Medicine*

**ANTIBIOTIC CHOICES AND HOW TO MAKE THEM**
**For:** MD's, interns. Lecture, Nov. 15, 11:00 a.m.-12:00 noon, Chicago. **Speaker:** Mary Carruthers, MD. **Fee:** none. **Reg. limit:** none. **CME Credit:** AMA Category 1, 1 hour; AAFP Elective, 1 hour. **Contact:** Fernando Villa, MD. **Phone:** 312-583-9000 x 331.

### *Obstetrics/Gynecology*

**OBSTETRICS/GYNECOLOGY IN GENERAL PRACTICE**
**For:** MD's, office staff. Symposium, Nov. 16, 7:00-10:00 p.m., Mt. Vernon. **Sponsor:** SIU School of Medicine, 801 No. Rutledge Ave., P.O. Box 3926, Springfield, IL 62708. **Fee:** $25 pre. **Reg. limit:** none. **CME Credit:** AMA Category 1, 3 hours. **Contact:** Lorraine Stephenson. **Phone:** 217-782-7711.

### *Obstetrics/Gynecology*

**PERINATAL MEDICINE SYMPOSIUM**
**For:** MD's, office staff. Symposium, Nov. 9, 8:00-4:30 p.m., Springfield. **Sponsor:** SIU School of Medicine, 801 No. Rutledge, P.O. Box 3926, Springfield, IL 62708. **Fee:** $55 pre. **Reg. limit:** none. **CME Credit:** AMA Category 1, 6 hours. **Contact:** Lorraine Stephenson. **Phone:** 217-782-7711.

### *Pediatric Allergy*

**ALFRED S. TRAISMAN MEMORIAL LECTURE**
**For:** MD's. Lecture Nov. 8, 12:00 noon, Chicago. **Speaker:** Harvey Colten, MD. **Sponsor:** Children's Memorial Hospital, 707 W. Fullerton, Chicago 60614. **Fee:** none. **Reg. limit:** none. **CME Credit:** AMA Category 1, 1 hour; AAFP Elective, 1 hour. **Contact:** Howard Traisman, M.D. **Phone:** 312-869-4300.

### *Pediatrics*

**PRIMARY CARE PEDIATRICS—A GENERAL OVERVIEW**
**For:** Pediatricians, GP's, FP's. Lecture, Nov.-Jan., 2nd/4th Wednesday, Chicago. **Sponsor:** Grant Hospital, 550 W. Webster, Chicago 60614. **Fee:** none. **Reg. limit:** none. **CME Credit:** AMA Category 1. **Contact:** P. Colon. **Phone:** 312-883-2112.

*Psychiatry, Psychology*

**SETTING UP A SEX CLINIC**
**For:** MD's, Psychiatrists. Lecture, Nov. 15, 1:00-4:00 p.m., Forest Park. **Speaker:** Domeena Renshaw, MD. **Sponsor:** Riveredge Hospital Foundation, 8311 W. Roosevelt Road, Forest Park, IL 60130. **Fee:** $15. **CME Credit:** AMA Category 1, 3 hours. **Contact:** Susan Cosgrove. **Phone:** 312-771-7000.

*Surgery*

**ENTERAL & PARENTERAL HYPERALIMENTATION**
**For:** MD's, office staff. Symposium, Nov. 1, 8:00-5:00 p.m., Springfield. **Sponsor:** SIU School of Medicine, 801 No. Rutledge, P.O. Box 3926, Springfield, IL 62708. **Fee:** $55 pre. **Reg. limit:** none. **CME Credit:** AMA Category 1, 6 hours. **Contact:** Lorraine Stephenson. **Phone:** 217-782-7711.

*Surgery*

**SPINAL PROBLEMS**
**For:** MD's, office staff. Symposium, Nov. 15, 8:00-12:00 noon, Belleville. **Sponsor:** SIU School of Medicine, 801 No. Rutledge, P.O. Box 3926, Springfield, IL 62708. **Fee:** $25 pre. **Reg. limit:** none. **CME Credit:** AMA Category 1, 4 hours. **Contact:** Lorraine Stephenson. **Phone:** 217-782-7711.

*Surgery*

**RHEUMATOLOGY & JOINT RECONSTRUCTION**
**For:** MD's, office staff. Symposium, Nov. 9, 3:00-8:00 p.m., Quincy. **Sponsor:** SIU School of Medicine, 801 No. Rutledge, P.O. Box 3926, Springfield, IL 62708. **Fee:** $28 pre. **Reg. limit:** none. **CME Credit:** AMA Category 1, 4 hours. **Contact:** Lorraine Stephenson. **Phone:** 217-782-7711.

*Surgery—Medicine*

**TUMOR CONFERENCE**
**For:** open. Weekly lecture, Thursdays, 12:00 noon, Evanston. **Sponsor:** St. Francis Hospital, 355 Ridge Ave., Evanston, IL 60202. **Fee:** none. **Reg. limit:** none. **Contact:** Mitchel Byrne, MD. **Phone:** 312-492-6227.

*Parent-Infant Bonding and Child Abuse*

**PROMOTION OF PARENT-INFANT BONDING—AN EFFECTIVE STEP TOWARD PREVENTION OF CHILD ABUSE**
**For:** MD's, nurses, social workers. Symposium, Nov. 2, 8:00 a.m.-4:00 p.m., Champaign. **Sponsor:** Carle Clinic Association and Carle Foundation, Education Dept., 602 W. University, Urbana, IL 61801. **Cosponsor:** UI School of Clinical Medicine. **Fee:** $25. **Reg. limit:** none. **CME Credit:** AMA Category 1, 6 hours; AAFP Elective, 6 hours. **Contact:** Annette Lansford, MD. **Phone:** 217-337-3100.

# *DECEMBER*

*Colposcopy*

**COLPOSCOPY**
**For:** MD's. Conference, Dec. 8-9, Chicago. **Sponsor:** Northwestern University Medical School, Alumni Center for Continuing Education, 301 E. Chicago Ave., Chicago 60611. **Fee:** $150. **CME Credit:** AMA Category 1, 12 hours. **Contact:** James Dyson, Ph.D. **Phone:** 312-649-8533.

*Family Medicine*

**UPDATE—PRIMARY CARE MEDICINE**
**For:** GP's, FP's, Internists. Lectures, Dec. 12 & 15, 8:00 a.m., Chicago. **Sponsor:** Grant Hospital, 550 W. Webster, Chicago 60614. **Fee:** none. **Reg. limit:** none. **CME Credit:** AMA Category 1, 2 hours. **Contact:** P. Colon. **Phone:** 312-883-2112.

*Family Therapy*

**TECHNIQUES FOR WORKING WITH SEVERELY DISTURBED FAMILIES**
**For:** MD's. Workshop, Dec. 1, 9:30-4:30 p.m., Chicago. **Speaker:** Froma Walsh, Ph.D. **Sponsor:** Center for Family Studies/The Family Institute of Chicago, 10 E. Huron St., Chicago 60611. **Cosponsors:** Institute of Psychiatry, Northwestern Memorial Hospital, Northwestern University Medical School. **CME Credit:** AMA Category 1, 6 hours. **Contact:** Wendy Brockington. **Phone:** 312-649-7285.

*Forensic Medicine*

**REVIEW OF CURRENT FORENSIC PATHOLOGY CASES**
**For:** MD's, DDS's, LIB's. Workshop/lecture, Thursdays, 2:00 p.m., Chicago. **Sponsor:** Office of the Medical Examiner, Cook County, Illinois, Chicago. **Fee:** none. **Reg. limit:** 50. **Contact:** Robert Stein, MD. **Phone:** 312-443-5017.

*Internal Medicine*

**JAUNDICE**
**For:** MD's, office staff. Symposium, Dec. 7, 1:00-5:00 p.m., DuQuoin. **Sponsor:** SIU School of Medicine, 801 No. Rutledge, P.O. Box 3926, Springfield, IL. **Fee:** $25 pre. **Reg. limit:** none. **CME Credit:** AMA Category 1, 4 hours. **Contact:** Lorraine Stephenson. **Phone:** 217-782-7711.

*Obstetrics/Gynecology*

**OBSTETRICS & OFFICE GYNECOLOGY**
**For:** MD's, office staff. Symposium, Dec. 7, 5:00-9:00 p.m., Lawrenceville. **Sponsor:** SIU School of Medicine, 801 No. Rutledge, P.O. Box 3926, Springfield, IL 62708. **Fee:** $25 pre. **Reg. limit:** none. **CME Credit:** AMA Category 1, 4 hours. **Contact:** Lorraine Stephenson. **Phone:** 217-782-7711.

*Psychiatry*

**OFFICE PSYCHIATRY**
**For:** MD's, office staff. Symposium, Dec. 14, 7:00-10:00 p.m., Effingham. **Sponsor:** SIU School of Medicine, 801 No. Rutledge, P.O. Box 3926, Springfield, IL 62708. **Fee:** $25 pre. **Reg. limit:** none. **CME Credit:** AMA Category 1, 3 hours. **Contact:** Lorraine Stephenson. **Phone:** 217-782-7711.

*Psychiatry*

**INTRODUCTION TO THE ART OF SELF-CARE & CONFLICT MANAGEMENT**
**For:** Psychiatrists, MD's. Lecture, Dec. 20, 1:00-4:00 p.m., Forest Park. **Speaker:** Yetta Bernhard, MS. **Sponsor:** Riveredge Hospital Foundation, 8311 W. Roosevelt Road, Forest Park, IL 60130. **Fee:** $15. **CME Credit:** AMA Category 1, 3 hours. **Contact:** Susan Cosgrove. **Phone:** 312-771-7000.

**Introduction to CME Techniques**

**Two-day intensive workshop, Dec. 1-2. For: Hospital DME's, Program Chairmen, Medical Faculty, CME Planners. Leaders: Donald F. Pochyly, M.D., and Leonard S. Stein, Ph.D. Sponsor: ICCME. Oak Brook Hyatt House, Oak Brook, IL. Credit: AMA and IL license Category 1, 14 hours. Contact: Diane Wolniewicz, ICCME, 55 E. Monroe, Chicago 60603. Phone: (312) 236-6110.**

**RECENT CME ACCREDITATION RECOMMENDATIONS**

**The ISMS Committee on CME Accreditation has recently recommended to Liaison Committee-CME approval of the CME programs of the following institutions.**

**Elgin Mental Health Center**
**Elgin**

**Highland Park Hospital**
**Highland Park**

**Illinois Heart Association**
**Springfield**

**Illinois Masonic Medical Center**
**Chicago**

**Illinois Thoracic Surgical Society**
**Chicago**

**Memorial Hospital of DuPage County**
**Elmhurst**

**Riveredge Hospital**
**Forest Park**

**St. Elizabeth's Hospital**
**Chicago**

**St. Francis Hospital**
**Blue Island**

**SwedishAmerican Hospital**
**Rockford**

# *JANUARY*

*Family Medicine*

**ETHICAL ISSUES IN CRITICAL CARE**
**For:** GP's. Lecture, Jan. 10, 2:00-5:00 p.m., Chicago. **Sponsor:** The University of Chicago Medical Center, Frontiers of Medicine, 950 E. 59th St., Box 451, Chicago 60637. **Fee:** $20. **Reg. limit:** none. **CME Credit:** AMA Category 1, 3 hours; AAFP Elective, 3 hours. **Contact:** Elaine Ehrman. **Phone:** 312-947-5777.

*Family Medicine*

**UPDATE—PRIMARY CARE MEDICINE**
**For:** GP's, FP's, Internists. Lectures, Jan. 5 & 26, 8:00 a.m., Chicago. **Sponsor:** Grant Hospital, 550 W. Webster, Chicago 60614. **Fee:** none. **Reg. limit:** none. **CME Credit:** AMA Category 1, 2 hours. **Contact:** P. Colon. **Phone:** 312-883-2112.

*Family Therapy*

**PROBLEM-CENTERED SYSTEMS THERAPY—ASSESSMENT**
**For:** MD's. 2-day workshop, Jan. 18 & 19, 9:30 a.m.-4:30 p.m., Chicago. **Speaker:** William Pinsof, Ph.D. **Sponsor:** Center for Family Studies/The Family Institute of Chicago, 10 E. Huron, Chicago 60611. **Cosponsor:** Institute of Psychiatry, Northwestern Memorial Hospital, Northwestern University Medical School. **Reg. limit:** 100. **CME Credit:** AMA Category 1, 12 hours. **Contact:** Wendy Brockington. **Phone:** 312-649-7285.

*Family Therapy*

**PERSONAL/PROFESSIONAL GROWTH WORKSHOP FOR THERAPISTS: WITH OR WITHOUT PARTNERS**
**For:** MD's, therapists. Seminar, Jan. 25, 26, 27, Oak Park. **Speaker:** Charles Kramer, MD. **Sponsor:** Center for Family Studies/The Family Institute of Chicago, 10 E. Huron, Chicago 60611. **Cosponsors:** Institute of Psychiatry, Northwestern Memorial Hospital, Northwestern University Medical School. **Reg. limit:** 16. **CME Credit:** AMA Category 1, 17 hours. **Contact:** Wendy Brockington. **Phone:** 312-649-7285.

*Family Therapy*

**LAW IN THE EVERYDAY PRACTICE OF PSYCHOTHERAPY**
**For:** MD's. Workshop, Jan. 26 & 27, 9:30-4:30 p.m., Chicago. **Speaker:** Sandra Nye, JD, MSW. **Sponsor:** Center for Family Studies/The Family Institute of Chicago, 10 E. Huron, Chicago 60611. **Cosponsors:** Institute of Psychiatry, Northwestern Memorial Hospital, Northwestern University Medical School. **Reg. limit:** 40. **CME Credit:** AMA Category 1, 12 hours. **Contact:** Wendy Brockington. **Phone:** 312-649-7285.

*Forensic Medicine*

**REVIEW OF CURRENT FORENSIC PATHOLOGY CASES**
**For:** MD's, DDS's, LIB's. Workshop/lecture, Thursdays, 2:00 p.m., Chicago. **Sponsor:** Office of the Medical Examiner, Cook County, Illinois, 1828 W. Polk St., Chicago 60612. **Fee:** none. **Reg. limit:** 50. **Contact:** Robert Stein, MD. **Phone:** 312-443-5017.

*Medicine*

**14th ANNUAL MEETING**
**For:** FP's. Symposium/workshop, Jan. 14-19, Las Vegas, Nevada. **Speaker:** Michael De Bakey, MD. **Fee:** $250. **Reg. limit:** none. **CME Credit:** AMA Category 1, 40 hours. **Sponsor:** American Society of Contemporary Medicine and Surgery, 6 No. Michigan Ave., Chicago 60602. **Contact:** John Bellows, MD. **Phone:** 312-236-4673.

*Ophthalmology*

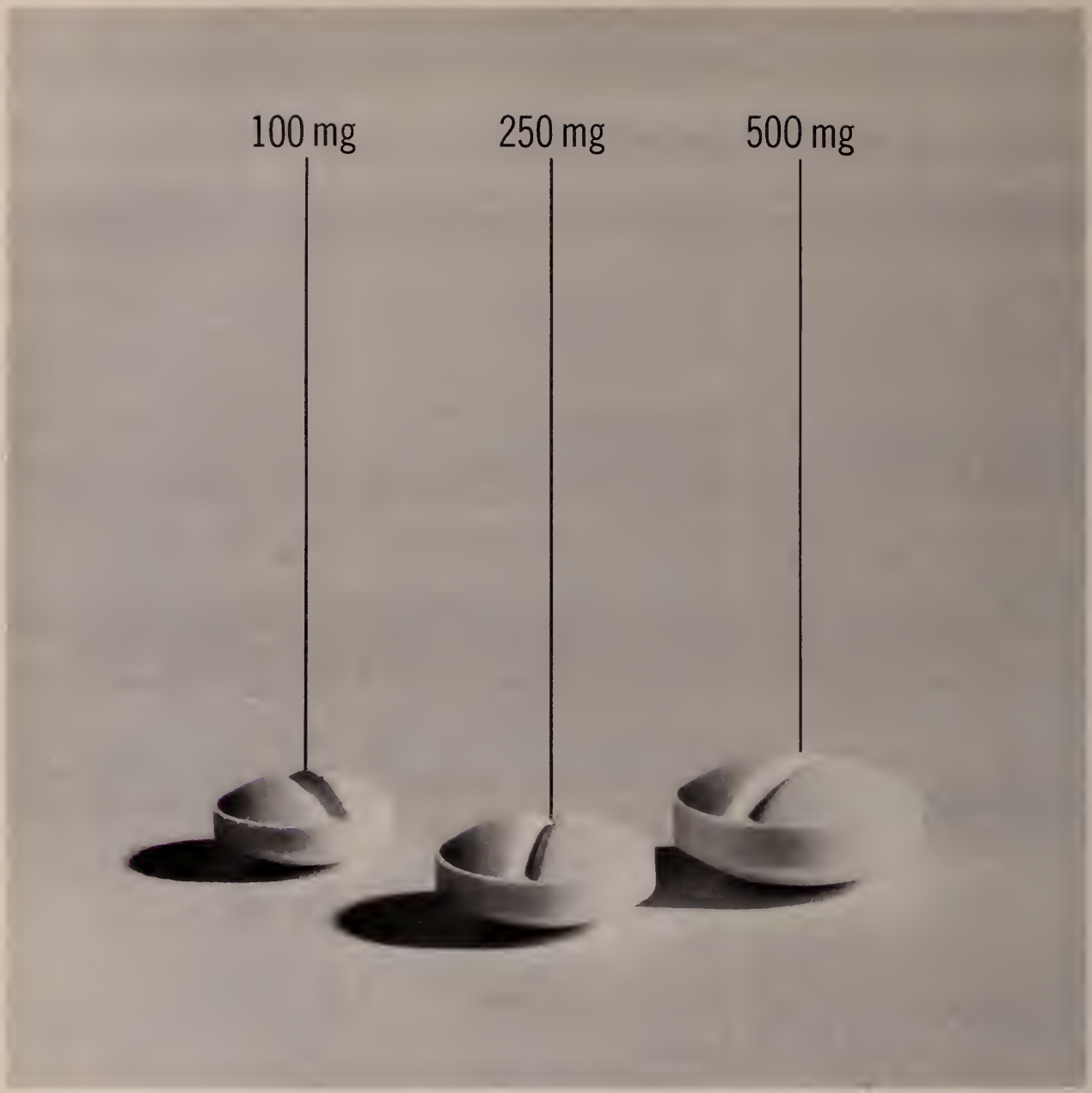
**14th ANNUAL SCIENTIFIC ASSEMBLY**
**For:** Ophthalmologists. Seminars/lectures/workshops, Jan. 14-19, Las Vegas, Nevada. **Sponsor:** American Society of Contemporary Ophthalmology, 6 No. Michigan Ave., Chicago 60602. **Fee:** $250. **Reg. limit:** none. **CME Credit:** AMA Category 1, 40 hours. **Contact:** John Bellows, MD. **Phone:** 312-236-4673.

*Ophthalmology*

**THE ROLE OF THE PRIMARY PHYSICIAN IN EYE CARE**
**For:** FP's, Internists, Pediatricians. Workshop, 3 sessions in 1979, Chicago. **Sponsor:** Dept. of Ophthalmology, University of Illinois, 1855 W. Taylor, Chicago 60612. **Fee:** $200/session. **Reg. limit:** 40. **CME Credit:** AMA Category 1. **Contact:** Carmen Carrasco. **Phone:** 312-996-8023.

*Psychiatry/Psychology*

**NARCISSISTIC FACTORS IN PSYCHOTHERAPY**
**For:** MD's, Psychiatrists. Lecture, Jan. 17, 1:00-4:00 p.m., Forest Park. **Speaker:** Arnold Goldberg, MD. **Sponsor:** Riveredge Hospital Foundation, 8311 W. Roosevelt Rd., Forest Park 60130. **Fee:** $15. **CME Credit:** AMA Category 1, 3 hours. **Contact:** Susan Cosgrove. **Phone:** 312-771-7000.




# Tolinase®
## tolazamide, Upjohn

Please contact your Upjohn representative for additional product information.

Upjohn

J-5695-6

©1977 THE UPJOHN COMPANY

IMJ
*Illinois Medical Journal*

Vol. 154, No. 4, October, 1978

# ISMS ORGANIZATION

## History of Founding and Expansion

Twenty-nine physicians met in Springfield June 4, 1850, to organize on a permanent basis the Illinois State Medical Society, which had been started informally 10 years earlier. The founders were concerned with the solution of ethical, scientific, legislative and economic problems. The first Constitution and Bylaws and the first Code of Medical Ethics were adopted, the first legislative committee was appointed, and a resolution outlining the beginnings of interprofessional relations was approved.

The Legislative Committee was instructed to "memorialize the legislature at its next session, praying the enactment of a statute providing for the registration of Births, Deaths and Marriages." The resolution ruled that "members of the Society will discourage the sale of patent or secret nostrums on the part of Druggists and Apothecaries throughout the State, and will patronize insofar as practicable, only those who abstain from the sale of such patent or secret nostrums."

The first full time secretary of the Society was Dr. Harold M. Camp who served for over 35 years until his death in 1959. The first executive administrator, Robert L. Richards, was employed at the time the office was moved to Chicago in 1960 and served until February, 1966. After an interim service by Dr. George F. Lull, Mr. Roger N. White was selected as Executive Administrator in May, 1968.

The Society published the early transactions in book form presenting not only the minutes of the House of Delegates, but also all scientific papers given at each annual convention. In 1899 a new era of communications began, for at that time, the *Illinois Medical Journal* was established and became the first "official organ of the Society."

Dr. G. N. Kreider was its first editor and served until 1913, followed by Dr. Clyde D. Pence with Dr. Henry G. Olds as the first managing editor. Dr. Charles G. Whalen became editor in 1919 and he and Dr. Olds served until they died in 1940. Dr. Camp followed Dr. Whalen, and Dr. Theodore R. Van Dellen was the editor for 18 years ending 1977. Subsequently, an Editorial Board was established to review and determine clinical content for the *IMJ*. The Editorial Board reports to the ISMS Publications Committee.

Dr. Whalen spearheaded many important activities in medicine, and has been called "the outstanding champion of the medical profession in its economic contacts." He has been credited as one of the first medical editors to blast "the socialization of medicine in this country." In 1922, he wrote extensively on state medicine, workmen's compensation, compulsory health insurance, free hospitalization and federal aid.

The first Fifty Year Club in the United States was announced by the *Illinois Medical Journal* in 1938.

The fourth largest medical society in the country has developed from these embryonic beginnings. This edition of the *Illinois Medical Journal* offers you an opportunity to contrast the extensive services available to the membership today with those offered in the past.

ISMS Organization

# Principles Of Medical Ethics

PREAMBLE: These principles are intended to aid physicians individually and collectively in maintaining a high level of ethical conduct. They are not laws but standards by which a physician may determine the propriety of his conduct in his relationship with patients, with colleagues, with members of allied professions, and with the public.

SECTION 1—The principal objective of the medical profession is to render service to humanity with full respect for the dignity of man. Physicians should merit the confidence of patients entrusted to their care, rendering to each a full measure of service and devotion.

SECTION 2—Physicians should strive continually to improve medical knowledge and skill, and should make available to their patients and colleagues the benefits of their professional attainments.

SECTION 3—A physician should practice a method of healing founded on a scientific basis; and he should not voluntarily associate professionally with anyone who violates this principle.

SECTION 4—The medical profession should safeguard the public and itself against physicians deficient in moral character or professional competence. Physicians should observe all laws, uphold the dignity and honor of the profession and accept its self-imposed disciplines. They should expose, without hesitation, illegal or unethical conduct of fellow members of the profession.

SECTION 5—A physician may choose whom he will serve. In an emergency, however, he should render service to the best of his ability. Having undertaken the care of a patient, he may not neglect him; and unless he has been discharged he may discontinue his services only after giving adequate notice. He should not solicit patients.

SECTION 6—A physician should not dispose of his services under terms or conditions which tend to interfere with or impair the free and complete exercise of his medical judgment and skill or tend to cause a deterioration of the quality of medical care.

SECTION 7—In the practice of medicine a physician should limit the source of his professional income to medical services actually rendered by him, or under his supervision, to his patients. His fee should be commensurate with the services rendered and the patient's ability to pay. He should neither pay nor receive a commission for referral of patients. Drugs, remedies or appliances may be dispensed or supplied by the physician provided it is in the best interests of the patient.

SECTION 8—A physician should seek consultation upon request, in doubtful or difficult cases; or whenever it appears that the quality of medical service may be enhanced thereby.

SECTION 9—A physician may not reveal the confidences entrusted to him in the course of medical attendance, or the deficiencies he may observe in the character of patients, unless he is required to do so by law or unless it becomes necessary in order to protect the welfare of the individual or of the community.

SECTION 10—The honored ideals of the medical profession imply that the responsibilities of the physician extend not only to the individual, but also to society where these responsibilities deserve his interest and participation in activities which have the purpose of improving both the health and the well-being of the individual and the community.

# ILLINOIS STATE MEDICAL SOCIETY

## Constitution And Bylaws

### Adopted, 1903
### As Amended, 1978



## CONSTITUTION

### ARTICLE I. NAME

The name and title of this organization shall be the Illinois State Medical Society.

### ARTICLE II. PURPOSES OF THE SOCIETY

The purposes of this Society are to promote the science and art of medicine, to protect the public health, to elevate the standards of medical education and to unite the medical profession behind these purposes; to promote similar interests in the component societies and to unite with similar organizations in other states and territories of the United States to form the American Medical Association. The Society shall inform the public and the profession concerning the advancements in medical science and the advantages of proper medical care.

### ARTICLE III. COMPONENT SOCIETIES

Component societies shall consist of those county medical societies which hold charters from this Society.

### ARTICLE IV. COMPOSITION OF THE SOCIETY

The Society shall consist of active members and such other members as the Bylaws may provide.

### ARTICLE V. HOUSE OF DELEGATES

Section 1. The House of Delegates shall be the legislative body of the Illinois State Medical Society, and unless otherwise herein provided, its deliberations shall be binding upon the officers, including the Board of Trustees. The House of Delegates shall set the basic policy and philosophy of the Society.

Section 2. The House of Delegates shall elect the general officers, except as otherwise provided in the Bylaws.

### ARTICLE VI. OFFICERS

The officers of this Society shall be a president, a president-elect, a first vice president, a second vice president, a secretary-treasurer, a speaker and vice speaker of the House of Delegates, and such trustees and other officers as the Bylaws may provide.

### ARTICLE VII. BOARD OF TRUSTEES

The Board of Trustees, whose duties are executive and judicial, shall have charge of all property and all financial affairs of the Society, and shall perform such other duties as are prescribed by law governing the directors of corporations, or as may be prescribed in the Bylaws.

### ARTICLE VIII. CONVENTIONS AND MEETINGS

The Society shall hold an annual convention during which there shall be a business meeting of the House of Delegates which shall be open to all registered members.

### ARTICLE IX. THE SEAL

This Society shall have a common seal with power to break, change or renew the same when necessary.

### ARTICLE X. AMENDMENTS

The House of Delegates may amend this Constitution at any annual or interim business meeting of the House of Delegates provided that the amendment shall have been proposed at a preceding annual or interim business meeting, and that two-thirds of the members of the House of Delegates seated concur in the amendment.

## BYLAWS

### CHAPTER I. MEMBERSHIP

Section 1. *Members.* Members shall consist of Regular members, Associate members, Emeritus members, Retired members, Service members, Distinguished members, In-training members and Student members. Members enjoy full rights and privileges, including the right to vote and hold office and are counted in determining the strength of the Society's Delegation to the American Medical Association.

A. *Regular Members.* Regular members shall be those physicians licensed to practice medicine in all its branches in the State of Illinois, who are either residents of the State of Illinois or who practice principally in Illinois, are persons of good moral character and professional standing and members of their ISMS component society.

Members in good standing moving out of Illinois may retain membership (not to exceed one year) in the Illinois State Medical Society until they are accepted into membership in the medical society of the state to which they have moved.

Physicians serving as full-time employees of the American Medical Association and other physicians licensed in one of the states or territories of the United States but not licensed in Illinois may become regular members although they are not actively engaged in the practice of medicine.

B. *Associate Members.* Associate members are physicians who hold the degree of Doctor of Medicine, who have a hospital permit to practice medicine in the State of Illinois and are members of their component medical society.

C. *Emeritus Members.* Emeritus members are those who have been regular members in good standing for thirty-five years and have reached or will have reached the age of seventy before the next fiscal year of the Society, have made written application which is received by their component society prior to December 31 and have been recommended by their component society for emeritus status. Such membership shall be effective January first of the year following election. Credit for membership in other Amedican Medical Association constituent societies shall be accorded transferees, provided they have been members of the Society for at least five years.

D. *Retired Members.* Retired members shall consist of those who have been regular members and who by reason of age or incapacity have retired from active practice and who upon application and recommendation from their component society have been made retired members. Retired status is not available to physicians who assume compensated positions after retiring from medical practice.

E. *Service Members.* Physicians serving as medical officers in the United States Governmental Services, who are members of a component society, so long as they are engaged actively fulltime in their respective service, and thereafter if they have been retired on account of age or physical disability, shall be elected to service membership.

F. *Distinguished Members.* Physicians of Illinois or other states or foreign countries who have risen to prominence in the profession, teachers of medicine or of the sciences allied to medicine, not eligible for regular membership, or members of associated arts and sciences, who have made significant contributions to medicine may be nominated by any member of the House of Delegates and may be elected by the House at any annual convention by a two-thirds affirmative vote of those present and voting. They shall not be considered as members in determining the number of delegates to the American Medical Association, but they may participate in all other society activities.

G. *In-Training Members.* In-training members are persons who are medical school graduates, of good moral character and professional standing and serving an internship or residency approved by the American Medical Association in the State of Illinois and are members, of a component medical society. Membership shall end at the end of the year in which training is terminated. Following this, in-training members may apply for regular membership through their component society.

H. *Student Members.* Student members are those who are currently enrolled in an Illinois medical school or are Illinois residents enrolled in an approved medical school within the boundaries of the United States, are of good moral character, professional and academic standing and student members of a component society.

Section 2. *Discrimination of Membership.* Membership in the Illinois State Medical Society shall not be denied or abridged because of color, creed, race, religion, sex or ethnic origin.

Section 3. *Tenure and Termination.*

A. *Tenure of Membership.* The name of a physician on a properly certified roster of members of a component society which has paid its annual assessments, shall be prima facie evidence of membership in this society. The member shall retain his membership so long as he complies with the provisions of this Constitution and Bylaws and with the Principles of Medical Ethics of the American Medical Association. A member shall hold only one type of membership at any one time.

B. *Termination of Membership.* Any person who is under sentence of suspension or expulsion from a component society shall not be entitled to any of the rights or benefits of the society nor shall he be permitted to take part in any of the proceedings until he has been reinstated. Suspension will in no way affect insurance benefits.

A member whose dues are unpaid by March 31 of the current year ceases to be in good standing and shall be notified of his delinquency by the secretary. A member whose dues or assessments remain unpaid on April 30 of the current year shall automatically be dropped from membership. An individual who has forfeited membership for non-payment of dues or assessments may be reinstated as a member before two years have elapsed, providing, in the interim, he has not been guilty of conduct prejudicial to membership, by the full payment of all dues or assessments in arrears from the date that he was last in good standing. If two or more years have elapsed since he was a member in good standing, he will be required to make application as a new member.

Any member in good standing who resigns voluntarily by December 31 of any year may be reinstated within one year of his resignation by paying all dues and assessments that fell due during the period that his membership lapsed. If more than one year has elapsed since his resignation, he must apply as a new member. Any past member who regains membership by payment of all dues and assessments in arrears shall be eligible for membership benefits only to the extent and in the same manner as a new member initially joining the society.

## CHAPTER II. DUES, FUNDS AND ASSESSMENTS

Section 1. *Dues.* Annual dues may be levied by the House of Delegates on each class of membership. The amount of dues shall be recommended by the Board of Trustees and shall be fixed by the House of Delegates at the Annual Meeting and shall include the dues and/or assessments approved by the House of Delegates of the American Medical Association. These shall include the annual subscription to the *Illinois Medical Journal* which shall be at least fifty percent of the regular subscription price of the *Journal.* Only Regular, Associate, In-training and Student members shall be assessed annual dues. Dues for its members shall be forwarded by the component society prior to March 31 of each year.

Section 2. *Reduction and Remission of Dues.* Physicians in private practice of medicine may be given a fifty percent reduction in dues during the first year of practice, upon recommendation of their component society. Physicians approved for membership after June 30 shall pay one-half the annual dues for that year. The Board of Trustees may authorize remission of dues of any member on recommendation of his component society for good reason. In such cases the secretary shall recommend remission of dues by the American Medical Association. Emeritus members, Retired members, Service members and Distinguished members are not required to pay dues.

Section 3. *Assessments and Funds.* In addition to dues, assessments may be made on dues-paying members as may be recommended by the Board of Trustees and approved by the House of Delegates. Unless specifically indicated as voluntary, any assessment passed by the ISMS House of Delegates shall be considered a part of a member's dues for the purposes of membership in this organization.

## CHAPTER III.
## EDUCATIONAL AND SCIENTIFIC PROGRAMS

Educational and scientific programs shall be provided by the Society at such times and places as recommended by the Board of Trustees and approved by the House of Delegates.

## CHAPTER IV. HOUSE OF DELEGATES

Section 1. *Composition.* The voting membership of the House of Delegates shall consist of 1) delegates elected by component societies, 2) the President, 3) the President-elect, 4) the Vice Presidents, 5) the Secretary-Treasurer, 6) the Speaker and Vice Speaker, 7) Trustees, and 8) one delegate elected by the Resident Physicians Section and one delegate elected by the Student Business Session.

Those having the privilege of the floor without vote are past trustees, past presidents, past speakers, general officers of the American Medical Association, and one representative from each member organization of the Council on Affiliate Societies.

Section 2. *Delegates.* Each component society shall be entitled to send one of its members to the House of Delegates each year for each seventy-five members, not to include student members, and one for a major fraction thereof, but each component society which has made its annual report and paid its assessment as provided for in this Constitution and Bylaws shall be entitled to one delegate. The number of delegates to which any component society is entitled shall be determined by the number of members of the component society on membership rolls of the Illinois State Medical Society as of December 31 of the preceding year. The term of office of a delegate shall begin January first following his election and shall be for two years, or until his successor has been elected. Component societies with only one delegate may elect for one year.

Section 3. *Affiliate Group Delegates.* There shall be a Resident Physicians Section and a Student Business Session, which shall be open, respectively, to all in-training and medical student members of ISMS. The business of each organization shall be conducted by a governing council in accordance with bylaws approved by the ISMS House of Delegates. The governing council of each organization shall include one delegate with vote in the ISMS House of Delegates and one alternate delegate.

Section 4. *Time and Place of Meeting.* The House of Delegates shall meet twice each year. These two meetings shall be designated as the annual meeting and the interim meeting. The time and place of both shall be as the House determines, except that the interim meeting should not exceed three days and it should be held in a district other than where the annual meeting is held.

Section 5. *Quorum.* Fifty delegates representing no less than twenty component societies shall constitute a quorum for the transaction of business.

Section 6. *Special meetings.* Special meetings of the House of Delegates may be called by a majority of the Board of Trustees or upon petition of twenty component societies. When a special meeting is called, the secretary shall mail a notice to the last known address of each member of the House of Delegates at least ten days before the special meeting is to be held. The notice shall specify the time and place of the meeting and the purpose for which the meeting is called. The meeting shall not consider any business except that for which it was called.

Section 7. *Registration.* Before being seated at any annual or special session, each delegate or his alternate shall deposit with the Reference Committee on Credentials a certificate signed by the President and/or the Secretary of his component society stating that the delegate or alternate has been regularly elected to the House of Delegates. A delegate or his alternate may be seated without credentials, provided he is properly identified and is certified to the secretary of the Illinois State Medical Society. Whenever a delegate or his alternate are unable to attend a particular meeting, the component society may select and certify a substitute delegate who shall have the same powers and duties as did the delegate. A delegate whose credentials have been accepted by the Reference Committee on Credentials and whose name has been placed on the roll of the House, shall remain a delegate until the final adjournment of that session. If a delegate, once seated, is unable to be present for reasons acceptable to the Committee on Credentials, an alternate may be certified by the committee. After the alternate has been seated, he cannot be replaced for that session.

Section 8. *District Division.* The House of Delegates shall divide the state into districts, specifying which counties each district shall include.

Section 9. *Order of Procedure.* The order of business of the House of Delegates shall be determined by the Speaker, subject to approval by the Reference Committee on Rules and Order of Business. Sturgis Standard Code of Parliamentary Procedure, Current Edition, shall be the guide for all procedure when not in conflict with the Constitution and Bylaws.

Section 10. *Privilege of the Floor.* The House of Delegates by two-thirds vote of those present and voting, may extend an invitation to address the House to any person who in its judgment might assist in its deliberations.

Section 11. *Introduction of Resolutions and Other Business.* All resolutions must be introduced by a voting member of the House. Resolutions submitted nine weeks prior to the annual or interim meeting of the House will be listed in the delegates handbook citing author and subject only; a full copy of all resolutions will be mailed to the delegates. Resolutions to be mailed to the delegates prior to the annual or interim meeting must be received at ISMS headquarters four weeks prior to the annual or interim meeting. Resolutions received after the above date except those originating from the RPS or SBS business sessions, must be approved by the Committee on Rules and Order of Business or by a two-thirds vote of the House of Delegates before they will be considered as business of the House. Resolutions presented from the business meeting of the Resident Physician Section or the Student Business Session may be presented for consideration by the House of Delegates at any time before the close of business of the first day session of the House of Delegates.

Reports of committees, councils and officers should be informational and should not contain requests for House action. Recommendations of committees, councils and officers should be submitted to the House in resolution form. Reports, resolutions and requests for action after the opening of the first session of the House of Delegates shall require for consideration a two-thirds affirmative vote.

## CHAPTER V. ELECTION OF OFFICERS

Section 1. *Officers.* The officers of this Society shall consist of the president, president-elect, first and second vice presidents, secretary-treasurer, speaker and vice speaker, twenty-one trustees and one trustee-at-large.

Section 2. *Elections.* All elections shall be by ballot except when there is only one candidate for a given office, then election may be by voice vote.

The majority of votes cast shall be necessary to elect.

The election of officers, delegates and alternate delegates to the AMA, shall follow the completion of action on current and old business at the final session of the House of Delegates.

Section 3. *Terms of Office.* The president-elect, vice-presidents, secretary-treasurer, the speaker and vice speaker shall be elected annually by the House of Delegates to serve for a term of one year.

Members of the Board of Trustees shall be elected by the House of Delegates to serve for a term of three years. The number of consecutive terms that may be served by a trustee is limited to three. This shall become effective July 1, 1975, and shall not have retroactive application.

The speaker and vice speaker shall not be elected for more than two consecutive terms to their respective offices; they shall be elected from the membership of the House of Delegates.

The president-elect shall be inducted into the office of president by the retiring president during the final session of the House of Delegates. After assuming office at the adjournment of the annual business meeting, he shall continue in office until his successor has been elected and installed. Following his retirement as president, he shall automatically become trustee-at-large for a term of one year.

## CHAPTER VI. DUTIES OF OFFICERS

Section 1. *The President.* The president of the Illinois State Medical Society shall lead the Society in all its functions. He shall deliver an annual address at such time as may be arranged, and perform such other duties as custom and parliamentary usage may require.

Section 2. *The President-Elect.* The president-elect shall serve as the chairman of the Committee on Planning and Priorities.

Section 3. *The Vice Presidents.* The vice presidents shall act for and perform such duties for the president as he shall direct. They shall, when so acting, implement and advance the programs and policies of the president.

In the event of the president's death, resignation or removal from office, the first vice president shall succeed to the presidency.

In the event of a vacancy in the office of first vice president, the second vice president will become first vice president.

Section 4. *Successor to President-Elect.* In the case of death, resignation, or removal from office of the president-elect, the office shall be filled by the House of Delegates at the next annual convention by election at a time recommended by the Reference Committee on Rules and Order of Business.

Section 5. *The Speaker.* The speaker, who shall be versed in parliamentary procedure, shall preside at the meetings of the House of Delegates and shall perform such duties as custom and parliamentary usage require.

He shall appoint all committees of the House of Delegates.

He shall seek the advice of officers and trustees.

He shall be a member of the Committee on Constitution and Bylaws.

Section 6. *The Vice Speaker.* The vice speaker shall preside for the speaker in the latter's absence at his request. In case of death, or resignation of the speaker, the vice-speaker shall serve during the unexpired term.

Section 7. *The Secretary-Treasurer.* In addition to the rights and duties ordinarily devolving on the secretary of a corporation by law, custom or parliamentary usage, and those granted or imposed in other provisions of the Constitution and these Bylaws, the secretary-treasurer shall be the official custodian of all securities and the income therefrom owned by the Society, subject to the direction and disposition of the Board of Trustees. He shall be a member of the Finance Committee of the Board of Trustees.

The Board of Trustees may select a bank or trust company to act as custodian in the place of the secretary-treasurer, of all or any part of such securities and to act as agent of the Society in collecting the income therefrom.

He shall perform such other duties as may be directed by the House of Delegates or by the Board of Trustees.

In the event of a vacancy in the office of the secretary-treasurer, the Board of Trustees shall fill the vacancy until the next annual election.

Section 8. *Delegates and Alternate Delegates to the American Medical Association.* Members of the Illinois State Medical Society's delegation to the American Medical Association are officers of this society and, as such, share jointly with the Board of Trustees the responsibility for carrying out policies established by the ISMS House of Delegates as they pertain to the AMA activities.

Members of the delegation are responsible for participating actively in the House of Delegates of ISMS and the AMA to the extent allowed under the bylaws of each organization. They are responsible for submitting to the AMA appropriate resolutions and they are obliged to seek passage of these resolutions in the AMA House of Delegates until such time as circumstances and/or additional facts make continued effort impractical or impossible.

## CHAPTER VII. THE BOARD OF TRUSTEES

Section 1. *Composition.* The Board of Trustees shall consist of: twenty-one trustees elected by the House of Delegates, one trustee-at-large (the retiring president, who shall serve a term of one year), the president, the president-elect, the speaker and vice speaker of the House of Delegates, the first vice president and second vice president, and the secretary-treasurer. Ten trustees shall be chosen from District 3 and one from each of the other eleven districts.

The trustee districts of the Illinois State Medical Society shall be:

First District—Counties of Kane, Lake, McHenry.

Second District—Counties of Bureau, LaSalle, Livingston, Marshall, Putnam, Woodford.

Third District—Cook County.

Fourth District—Counties of Fulton, Hancock, Henderson, Henry, Knox, McDonough, Mercer, Peoria, Rock Island, Schuyler, Stark, Warren.

Fifth District—Counties of DeWitt, Logan, McLean, Mason, Menard, Montgomery, Sangamon, Tazewell.

Sixth District—Counties of Adams, Brown, Calhoun, Cass, Greene, Jersey, Macoupin, Madison, Morgan, Pike, Scott.

Seventh District—Counties of Bond, Christian, Clay, Clinton, Effingham, Fayette, Macon, Marion, Moultrie, Piatt, Shelby.

Eighth District—Counties of Champaign, Clark, Coles, Crawford, Cumberland, Douglas, Edgar, Jasper, Lawrence, Richland, Vermilion.

Ninth District—Counties of Alexander, Edwards, Franklin, Gallatin, Hamilton, Hardin, Jackson, Jefferson, Johnson, Massac, Pope, Pulaski, Saline, Union, Wabash, Wayne, White, Williamson.

Tenth District—Counties of Monroe, Perry, Randolph, St. Clair, Washington.

Eleventh District—Counties of DuPage, Ford, Grundy, Iroquois, Kankakee, Kendall, Will.

Twelfth District—Counties of Boone, Carroll, DeKalb, Jo Daviess, Lee, Ogle, Stephenson, Whiteside, Winnebago.

Section 2. *Duties.* The duties of the Board of Trustees are executive, custodial and judicial.

A. *Executive Duties.* The Board of Trustees shall implement all mandates from the House of Delegates except in matters of property or finance when it shall have sole authority.

The Board of Trustees may establish a not-for-profit corporation of physicians known as the Illinois Foundation for Medical Care.

The Board of Trustees may request a report from any committee in the interim between meetings of the House of Delegates.

B. *Custodial Duties.* The Board of Trustees shall have charge and control of all property of whatsoever nature belonging to the Society, and of all funds from whatsoever source belonging to the Society.

No person shall expend or use for any purpose money belonging to the Society without the approval of the Board of Trustees.

All money received by the Board of Trustees and its agents, resulting from the duties assigned them, shall be paid into the treasury of the Society, and all orders on the treasury for disbursement of money shall be approved by the Board.

The Board of Trustees shall formulate rules governing the expenditure of money to meet the necessary running expenses and fixed charges of the Society.

All acts of the House of Delegates involving the expenditure, appropriation or use in any manner of money, or the acquisition or disposal in any manner of property of any kind belonging to the Society, must be approved by the Board of Trustees before same shall become effective.

Funds may be appropriated to encourage scientific investigation, medical education or any other purpose deemed proper and approved by the Board of Trustees.

C. *Judicial Duties.* The Board of Trustees shall be the board of censors of the Society. It shall have jurisdiction over all questions of ethics and in the interpretation of the laws of the Society. It shall consider all questions involving the rights and standing of members, whether in relation to other members, to component societies, or to this Society.

All questions of an ethical nature before the House of Delegates or the general scientific meetings, shall be referred to the Board of Trustees without discussion. The Board shall hear and decide all questions of procedure affecting the conduct of members on which an appeal is taken from the decision of a component society.

The decision of the Board of Trustees shall be final except that an appeal may be taken by a member charged with misconduct as provided for in the Constitution and Bylaws of the American Medical Association.

Section 3. *Executive Administrator.* The Board of Trustees shall employ an executive administrator (who, when he shall be a physician, may be designated as the executive vice-president) whose duties shall be determined by the Board. He shall be responsible to the chairman of the Board. The Board shall review at each of its meetings the interim activities of the administrator. The Board also shall employ such other people as are needed for the conduct of the affairs of the Society.

Section 4. *Meetings.* The Board of Trustees shall meet daily during the annual convention of the Society, and at such other times as necessity may require, subject to the call of the chairman, or on the petition of the majority of the Trustees.

Section 5. *Organization.*

A. *Chairman.* The Board of Trustees shall meet on the last day of the annual convention and elect from among its members a chairman. He shall hold office for one year and may succeed himself for one additional year. The immediate past president shall temporarily assume the responsibilities of the Chairman of the Board in the latter's absence.

B. *Duties of the Chairman.* The chairman of the Board of Trustees shall prepare an agenda and shall preside at all meetings of the Board. He shall make an annual report to the House of Delegates. He shall be chairman of the Executive Committee. He shall present the report of the actions of the Executive Committee to the Board.

Section 6. *Quorum.* Eleven members of the Board of Trustees from at least seven districts shall constitute a quorum for the transaction of business.

Section 7. *County Societies.* The Board of Trustees shall have authority to organize the physicians of two or more counties into societies to be suitably designated, and these societies, when organized and chartered, shall be entitled to all rights and privileges provided for component societies until such counties shall be organized separately.

Section 8. *Publication.* The Board of Trustees shall provide and superintend the publication and the distribution of all proceedings, transactions and memoirs of the Society, and shall have authority to appoint an editor and such assistants as it deems necessary.

Section 9. *Bonding.* The Board of Trustees shall provide at the expense of the Society, adequate bond for those officers and employees of the Society it considers require bonding.

Section 10. *Duties of Trustees.* Each trustee shall be the organizer, consultant, advisor, administrator and speaker for the members of his district, and represent the Society as well as the members of his district at the Board meetings.

Each trustee should visit the societies in his district at least once a year. He shall make an annual report of his work and the condition of the profession in each society in his district to the Board of Trustees and to the House of Delegates.

Where his district is composed of more than one county, the trustee shall be an ex-officio member of all district committees. He shall report to the Board of Trustees the actions of the component societies in reports of these committees.

The necessary traveling expenses incurred by such trustee in the line of the duties herein imposed, may be allowed by the Board of Trustees upon presentation of a properly itemized statement.

Section 11. *Vacancies.* If during the interval between two annual conventions, sickness, death, or removal from

the state or district, or any other reason prevents a trustee from attending the duties of his district, or if he shall be absent from two consecutive meetings of the Board, his office may be declared vacant at the discretion of the Board. The Board shall have the authority to fill the vacancy for the period between the date at which the office was declared vacant and the next annual meeting of the House of Delegates.

Section 12. *The Benevolence Fund.* Each year the Board shall appropriate from the funds of this Society such sum or sums as it may deem proper to be held in a fund to be known as "The Benevolence Fund." This fund is established and shall be used only for the assistance or relief of needy members of this Society, their widows, widowers, or minor children. The assets shall be held in the treasury of this Society in a separate fund. Donations or bequests to the Benevolence Fund automatically become a part of these assets.

Section 13. *Audit and Financial Statement.* The Board of Trustees shall employ annually a certified public accountant to audit all accounts of the Society, and present a statement of same in its annual report to the House of Delegates.

This report also shall specify the character and cost of all publications of the Society during the year, and the amount of all other property belonging to the Society under its control, with such suggestions as it may deem necessary.

## CHAPTER VIII. DISTRICT COMMITTEES

Each trustee district which is composed of more than one county, shall have an Ethical Relations Committee, a Peer Review Committee, and such other committees as required to provide to each component society those services the component society may not be able to provide for itself. District committees shall function only at the request of a component society within the district.

Complaints initially received by district committees shall be referred immediately to the component society for action.

District committees shall be governed by the procedural rules and regulations governing the counterpart state society committee or by these Bylaws.

Reports of findings and recommendations of these district committees shall be made to the component society which requested action.

The district trustee shall include a summary of the activities of each of these committees and the findings in general, in his annual report to the House of Delegates.

The committee members shall be elected at a meeting of the delegates of the district called by the trustee of the district, before or during the annual convention of the Illinois State Medical Society. Chairmen of the committees shall be designated by the trustee of the district, and the trustee shall be an ex-officio member of each committee.

## CHAPTER IX. COMMITTEES

Section 1. *Committee Structure.* The committee structure of the Illinois State Medical Society shall be as follows:

A. Councils (standing committees)
B. House of Delegates Committees
C. Board of Trustees Committees
D. Ethical Relations Committee (Chapter XI of these Bylaws)

Section 2. *Councils.*

A. The Medical-Legal Council shall be concerned in the areas of:
   1. Liaison with the Illinois Bar Association
   2. Liaison with courts, particularly where impartial medical testimony is involved.
   3. Implementation of the Impartial Medical Testimony Rule
   4. Legal aspects of medical practice other than in the area of mental health
   5. Licensing and standards of practice.
   6. Quackery
   7. Anatomical gifts and organ transplants

B. The Council on Governmental Affairs shall be concerned in the areas of:
   1. Federal and state legislation—analysis and communication
   2. Legislative liaison—both state and federal
   3. Political education

C. The Council on Education and Manpower shall be concerned in the areas of:
   1. Liaison with medical schools, curricula, etc.
   2. Health manpower and training
   3. Internships, residencies, etc.
   4. Scientific assembly
   5. Student loans
   6. Liaison with American Medical Student Association
   7. Continuing Medical Education

D. The Council on Economics and Peer Review shall be concerned in the areas of:
   1. Relations with governmental purchase of care programs (Medicare, Medicaid, Vocational Rehabilitation, etc.)
   2. Relations with prepayment, insurance and other third party plans.
   3. Fees and fee adjudication
   4. Health care cost and utilization
   5. Peer Review (Part 2 of Chapter XII of these Bylaws)

E. The Council on Medical Service shall be concerned in the areas of social and medical services and in environmental and community health.

F. The Council on Public Relations and Membership Services shall be concerned in the areas of:
   1. Publicity and promotion
   2. News media relations
   3. Exhibits and public service programming
   4. Religion and medicine
   5. New member orientation and membership benefit explanation

G. The Council on Mental Health and Addiction shall be concerned in the areas of:
   1. Facilities and services
   2. Liaison with Department of Mental Health
   3. Legal aspects of commitment, etc.
   4. Narcotics and dangerous drugs
   5. Alcoholism

H. The Council on Affiliate Societies shall be concerned in the areas of:
   1. Liaison between the affiliate society and ISMS.
   2. Scientific resource information and advice to ISMS.
   3. Consultation to other councils, e.g., postgraduate education, health care delivery, publicity, legislation.
   4. Advances of medical science in special fields.

I. Planning and Priorities Committee. This committee shall review the ongoing plans and programs, establish appropriate priorities and develop plans for future programs. In the discharge of its duties, it should assist the President-Elect in the formation of his objectives for accomplishment during his term as President. The President-Elect shall serve as the chairman of the committee.

Section 3. *Organization of Councils.*

A. Councils and the chairmen thereof shall be appointed by the Board of Trustees.

B. Each Council shall have authority to request the Board of Trustees to appoint subcommittees under the councils for any purpose within the functions of the Council. A member of the Council shall be designated as chairman of each subcommittee and shall be selected by the Board of Trustees. Each subcommittee shall be used only for the specific purpose or purposes assigned to it and shall terminate as soon as its final report has been made or at the direction of the Board. The chairman of a Council may not serve as chairman of any subcommittee of the Council.

C. Members of the Illinois State Medical Society (who are not voting members of the Board of Trustees) may be appointed to serve as chairmen or members of any council or committee. Students nominated by Illinois Chapters of the American Medical Student Association, or other recognized student organizations approved by the Illinois State Medical Society Board of Trustees to serve with Illinois State Medical Society members on appropriate committees, may by action of the Board of Trustees, be accorded membership in this classification for the term of the committee appointment. Such members shall be permitted full privileges of committee membership, including (with the permission of the House of Delegates) the right to speak on the floor of the House, but to have no vote out of committee. Voting members of the Board of Trustees may serve as advisory members to any council or committee.

Recommendations for membership on any committee may be submitted to the Board of Trustees by the House of Delegates, or in writing by any member of the Society.

A state committee which reviews the decisions of a similar committee of a component society may not have as a member one who currently serves on the same committee of a component society or district.

D. Each Council shall submit for adoption a budget for the ensuing year which shall include any subcommittees, and the Board of Trustees shall determine the appropriation for each Council. Requests for additional funds must be approved by the Board before they are committed.

E. The president of the Society, the speaker of the House and the chairman of the Board shall be ex-officio members without vote of the various Councils, and may attend all committee meetings.

F. Terms of office of members of the councils shall be one year, but may be terminated at any time at the discretion of the Board. No member of a council shall serve more than five consecutive one-year terms.

G. Vacancies on any council or subcommittee thereof may be filled or membership therein may be enlarged or decreased by the Board of Trustees. The areas of concern of councils may also be enlarged or decreased by the Board of Trustees.

H. The chairman of a council or subcommittee thereof, when he considers it expedient and with the consent of two-thirds of the members of the council, may conduct business or hold meetings by mail or by conference call, provided all members of the council are given opportunity to participate, that minutes of the transactions are recorded, approved by members participating, and circulated among all members.

I. Reports of subcommittees shall be made by the chairman to the council under which they are operating.

Reports of council activities shall include recommendations on reports and requests from subcommittees, and shall be made to the Board of Trustees by the chairman of the council.

The chairman of any subcommittee may request the Board of Trustees to allow him, or any member of his subcommittee, to appear before the Board and to be heard.

All councils shall submit to the House of Delegates written reports summarizing all actions. Requests for House action or recommendations affecting medical society policy must be submitted to the House in resolution form.

J. *Affiliate Societies*

1. *Qualifications.* Affiliate societies shall be those recognized societies of Illinois
   a) as may be approved by the Board of Trustees
   b) which desire representation on the Council on Affiliate Societies

2. *Representation.* Each affiliate society shall be entitled to one member on the council. This representative shall be a member of ISMS.

Section 4. *House of Delegates Committees.* House of Delegates Committees of the Illinois State Medical Society shall be as follows:

A. Committee on Credentials shall consider all questions regarding the registration and credentials of the delegates. It shall distribute and receive the attendance slips for each session of the House of Delegates and perform any other duties assigned to it.

B. Committee on Rules and Order of Business shall consider all matters regarding rules governing action, method of procedure and order of business for the House of Delegates.

C. Committee on Tellers and Sergeants-at-Arms shall:
1. Serve the speaker of the House of Delegates.
2. Distribute, collect and tally votes when a ballot is taken or a numerical tally is required.
3. Certify those in attendance in closed or executive sessions of the House of Delegates.

D. Committee on Changes in the Constitution and Bylaws shall consider all proposed amendments to the Con-

stitution and Bylaws. The chairman of the Trustees Committee on Constitution and Bylaws, or his representative, shall serve in an advisory capacity to this reference committee and shall attend all sessions, including the executive sessions of the reference committee, to assist in the preparation of the report of the committee to the House of Delegates.

E. Ad hoc committees may be appointed by the speaker of the House of Delegates as the needs arise and any member of the Illinois State Medical Society may serve upon such committee. The number appointed to such committees shall be at the discretion of the speaker and the term of the committee shall be for such duration as is necessary to complete the task assigned but shall not exceed a duration of one year. Between meetings of the House of Delegates ad hoc committees shall report to the Board of Trustees, keeping it informed of all current activities.

F. Such other reference committees as the speaker shall deem necessary to conduct the business of the House, or consider the reports of officers, trustees, executive administrator, the reports of committees pertaining to administrative activities, economic activities, scientific activities, public relations activities and legislative activities, as well as such resolutions, reports, and proposals as shall be brought before the House of Delegates.

Section 5. *Organization of House of Delegates Committees.*

A. Immediately after the organization of the House of Delegates at each annual or special meeting, the speaker shall announce the appointment, from among the members of the House, of such committees as may be deemed expedient by the House of Delegates.

Each committee shall consist of five or more members unless otherwise provided, the chairman to be announced by the speaker. These committees shall serve during the meeting at which they are appointed.

B. References, resolutions, measures and propositions presented to the House of Delegates shall be referred to the appropriate committee, which shall report to the House of Delegates before final action shall be taken. A two-thirds affirmative vote of the House of Delegates shall be required to suspend this rule.

C. Each reference committee shall, as soon as possible after the adjournment of each session, or during the session if necessary, take up and consider such business as may have been referred to it, and shall report on same at the next session, or when called upon to do so.

Section 6. *Board of Trustees Committees.* The Board of Trustees shall form the following committees within itself:

A. The Executive Committee shall consist of the president, president-elect, the first vice president, the chairman of the Board, the chairman of the Finance and Medical Benevolence Committee, the secretary-treasurer, the trustee-at-large, and the immediate past chairman of the Board, provided he is still a trustee. If the immediate past-chairman of the Board is no longer a trustee, the chairman of the Policy Committee shall be a member of the Executive Committee. The chairman of the Illinois Delegation to the American Medical Association, or the secretary in his absence, shall serve as an ex-officio member of the Executive Committee without vote.

The Board of Trustees may delegate to the Executive Committee any authority which it possesses and may authorize it to act in any given situation. In all matters of routine administration, special plans, policy, endorsement or expenditure it shall report to and request approval of the Board. It shall receive the reports of the Finance and Medical Benevolence Committee and Policy Committee and make recommendations concerning them to the Board. It shall furnish a report of its actions to the Board at each meeting.

B. The Finance and Medical Benevolence Committee shall consist of the secretary-treasurer of the Society and three members of the Board appointed by the chairman. It shall develop for approval of the Board through the Executive Committee, a budget for the fiscal year. It shall supervise the financial transactions of the Society. It shall make recommendations to the Board for the control and investment of the funds of the Illinois State Medical Society.

This committee shall also:

1. Examine applications to the Society for assistance under the Medical Benevolence to determine eligibility for assistance;
2. Keep the names of the beneficiaries confidential and known only to the committee;
3. Recommend the allotment for each recipient; and
4. If funds available become inadequate to meet disbursements, request the Board of Trustees to appropriate sufficient funds to support the program until the next budget appropriation.

C. The Policy Committee shall consist of three members of the Board appointed by the chairman. It shall continually review past and current proceedings of the House of Delegates to determine the established policies of the Illinois State Medical Society. It shall make recommendations for future policy by Board resolution to the House of Delegates.

D. The Ethical Relations Committee shall be constituted and function as stipulated in Chapter XI, Discipline, Part 2, Illinois State Medical Society procedures.

E. The Committee on Constitution and Bylaws shall consist of five members, the Speaker of the House and four members appointed by the Chairman of the Board. It shall:

I. Receive from individual members, county societies, committees, the Board of Trustees, and the House of Delegates, all suggestions and proposals for modification of the Constitution and Bylaws.

2. Prepare for the consideration of the House of Delegates, all changes in the Constitution and Bylaws.

3. Maintain constant surveillance of both documents to keep them current, effective and consistent with the policies of the House of Delegates.

F. The Committee on Publications shall be composed of five members of the Board of Trustees, and shall

be responsible for the production of the *Illinois Medical Journal.*

It shall recommend to the Board of Trustees all policies governing the editorial, business and production aspects of the *Journal.* It shall supervise the editor in the selection and preparation of all copy, and it shall establish standards for the editorial content.

It shall establish advertising policies, rates, standards, and shall review all new accounts prior to acceptance, and shall approve reprint and circulation policies.

It shall conduct a periodic review of the printer's contract and solicit bids as indicated. It shall establish format, cover, type faces and general layout of the *Journal.*

It shall review, edit and supervise the publication of other materials as directed by the Board of Trustees.

G. The Advisory Committee to the Auxiliary shall consist of the immediate past president as chairman, the president and the chairman of the Board of Trustees.

The committee shall provide advice and assistance to the president of the Auxiliary in her program for the year, and shall assist her in interpreting the activities of the Illinois State Medical Society.

H. The Board of Trustees may from time to time appoint such ad hoc committees as it may deem necessary but the duration of such committees shall be temporary and they shall function only for the specific purpose assigned and shall be terminated as soon as final reports have been made or at the direction of the Board.

Section 7. *Powers of the Board of Trustees.* The Board of Trustees shall have power to increase or decrease the number of its committees, to change the area of concern of such committees, to enlarge or decrease membership and to fill vacancies thereon.

Section 8. *Term of Membership.* The term of the members of the Board of Trustees Committees shall be for a duration of one year and they shall be selected by the Board annually immediately after the election of officers.

## CHAPTER X. COUNTY SOCIETIES

Section 1. All county societies now in affiliation with this Society, or those which may hereafter be organized in this state, which have adopted principles of organization in harmony with this Constitution and Bylaws, shall upon application to and approval by the Board of Trustees, receive a charter from and thereby become a component part of this Society, and members thereof shall become members of this Society and the American Medical Association.

Section 2. Charters shall be issued only on approval of the Board, and shall be signed by the president and the secretary of this Society.

The Board shall have authority to revoke the charter of any component society whose actions are in conflict with the letter and spirit of this Constitution and Bylaws.

Section 3. Only one component medical society shall be chartered in any county.

Section 4. Every registered physician holding the title of Doctor of Medicine or its equivalent, who either (1) resides in the jurisdiction of a component society, or (2) resides in a state other than Illinois but practices principally in the jurisdiction of a component society and who is of good moral character and professional standing, shall be eligible to membership in that component society.

The component county society shall be the sole judge of the qualifications of its members, subject only to the stipulations contained in the Constitution and Bylaws.

Section 5. Any physician who has been disciplined by any action of a component society and believes he has not had a fair trial, shall have the right of appeal to the Board of Trustees.

Section 6. When a member in good standing in a component society changes his residence to another county in this state, such change of residence shall terminate his membership in such component society. (This ruling shall not apply to members in military service or in the service of the State or the United States government.)

Such member shall be entitled, upon his request, to a statement from his former secretary as to his standing. This statement of standing shall be issued without cost to the applicant.

He shall present this statement to the component society of the county to which he removes and it shall accompany his application for membership. The board of censors of the society receiving this application shall give this statement of prior standing due consideration before accepting or rejecting his application for membership.

Section 7. A physician living on or near a county line, or practicing partly or totally in an adjacent county, may hold his membership in the county most convenient for him, provided he submits written authorization to that society from the component society in whose jurisdiction he resides.

Section 8. The secretary of each component society shall keep a roster of its members, in which shall be shown the full name, address, college and date of graduation, date of license to practice in this state, and such other information as may be deemed necessary. In keeping such a roster the secretary shall note any changes in the personnel of the profession by death or by removal to or from the county. When requested, he shall furnish on blanks supplied him for the purpose, an official report containing such information for the secretary of this Society and likewise for the trustee of the district in which his county is situated.

Section 9. The secretary of each component society shall forward an annual report consisting of a roster of members as of December 31 of the preceding year and a list of current officers, delegates and alternate delegates to the secretary of this society no later than 90 days prior to the annual meeting.

Section 10. Any component society which fails to transmit the dues collected from its members prior to March 31 shall be held as suspended and none of its members shall be permitted to participate in any of the business or proceedings of the Society or of the House of Delegates until such requirements have been met.

Section 11. The Constitution and Bylaws of the Illinois State Medical Society and of the American Medical Association, together with the Principles of Medical Ethics

of the American Medical Association, shall be binding upon members of the component societies.

## CHAPTER XI. DISCIPLINE

### PART 1. COMPONENT SOCIETY PROCEDURE

Section 1. *Local Ethical Relations Committee.* Each component society may have, either by appointment or election, an Ethical Relations Committee, whose duty it shall be to prosecute formal charges of unethical conduct. In the event that the county society does not have such a committee, the district Ethical Relations Committee shall function in its behalf.

All parties may have legal counsel present to advise and counsel them during the proceedings, but such counsel may not participate in the proceedings, and may be excluded from the hearing by the chairman or by vote of the committee.

The component society Ethical Relations Committee may establish reasonable rules of procedure, and they shall not be bound by the technical rules of evidence as the same pertain in courts of law. In all proceedings before such Ethical Relations Committees, the complainant, the accused and all witnesses before the committee shall be placed under oath.

The Committee shall evaluate acts by the standards established by the House of Delegates of the American Medical Association (specifically known as the Principles of Medical Ethics of the American Medical Association), and by such additional standards as shall be incorporated in the Constitution and Bylaws of the Illinois State Medical Society and/or the county medical society.

Section 2. *Offenses.* Any member of a component society shall be subject to censure, suspension or expulsion by such component society when:

A. He has been adjudged guilty by proper civil authorities of a criminal offense involving moral turpitude, or

B. He has been adjudged guilty by his component society in accordance with the procedural requirement of these bylaws:

   1. of a gross misconduct as a physician, or
   2. of a violation of the Constitution or Bylaws of his component society, or of the Illinois State Medical Society, or of the Principles of Medical Ethics promulgated from time to time by the American Medical Association.

Section 3. *Formal Written Charges Presented to the Illinois State Medical Society.* Formal, written charges received by the Illinois State Medical Society shall be referred directly to the secretary of the component society of which the charged individual is a member or to the district Ethical Relations Committee in the event that the component society does not have an Ethical Relations Committee.

Section 4. *Principles of Justice.* The following principles of justice shall guide the Ethical Relations Committee in all disciplinary procedures.

A. A charged individual is presumed to be innocent until he has been proven guilty.

B. No proceeding shall be initiated under this Part I until formal written charges have been filed with the secretary of the component society or the district Ethical Relations Committee, as the case may be. Thereafter, said formal written charges must be presented under oath or affirmation by the complaining party before the Ethical Relations Committee of the component society or the district Ethical Relations Committee, as the case may be.

C. A hearing shall be held by the committee within 30 days after the formal written charges have been filed, unless continued by the chairman of the committee upon good cause shown.

D. In the event that a component society's Ethical Relations Committee does not make a reasonable effort to hold the hearing within the time period, including reasonably granted continuances, either the complaining party or the physician, against whom formal written charges have been brought, may appeal for relief and hearing to the district Ethical Relations Committee, which will determine the reasonableness of the effort.

E. The individual against whom formal charges have been filed shall be sent a copy of said charges by certified mail at least 10 days before the date set for the hearing, together with a statement of the rights of the charged individual as follows:

   1. to be represented by any member of the society as counsel and that he may have legal counsel present;
   2. to cross-examine witnesses;
   3. to offer in evidence any pertinent records or documents;
   4. to object to any testimony or exhibits offered in evidence;
   5. to address the hearing body in his own behalf;
   6. to be tried only on the specific charges filed;
   7. to have stricken from the record any improper testimony or exhibits;
   8. to appeal to the Board of Trustees of the Illinois State Medical Society.

Section 5. *Records.* A comprehensive stenographic record, tape recording or its equivalent of the entire proceedings, together with all exhibits, must be kept for reference, and shall be available until final adjudication has been made.

In the event of an appeal being taken from the verdict of the local or district Ethical Relations Committee, the stenographic record, tape recording or its equivalent, of the entire proceedings shall be forwarded by certified mail to the Board of Trustees of the ISMS at least ten days prior to the date the appeal is to be heard.

If the component society fails to provide the record on appeal, the Ethical Relations Committee of Illinois State Medical Society shall find the charged individual not guilty.

Section 6. *Verdict.* The committee, sitting as a hearing body, shall recommend the charged individual be found either guilty or not guilty. If the verdict is guilty, the hearing body shall recommend censure, suspension or expulsion.

The findings of the hearing body must be presented to the component county society for approval or rejection. The charged individual must be notified by certified mail at least ten days before the date set for the meeting at which this action will be taken. If the findings of the component society are against the charged individual, the secretary of the component society shall acquaint the charged individual by certified mail, with his right of appeal within thirty days to the Board of Trustees of the Illinois State Medical Society.

## PART 2. ILLINOIS STATE MEDICAL SOCIETY PROCEDURES

Section 1. *Illinois State Medical Society Ethical Relations Committee.* The Board of Trustees shall appoint from its members, an Ethical Relations Committee to review decisions of the component society involving the interpretation of the Principles of Medical Ethics, violations of the Constitution and Bylaws of the Illinois State Medical Society or its component societies, and charges of misconduct of members of the Society.

Section 2. *Appeals from Component Society Verdicts.* Appeals received by the Illinois State Medical Society Board of Trustees shall be referred to the Ethical Relations Committee of the Board for review. (Appeals must be accompanied by a comprehensive stenographic record tape recording or its equivalent, of the entire proceedings taken before the component county society together with all exhibits submitted in evidence. If the component county society fails to provide the record on appeal, the Ethical Relations Committee of the Illinois State Medical Society shall find the accused "not guilty"). The committee shall notify the accused and the secretary of the component society by certified mail at least thirty days prior to the date set for the hearing of the appeal. The chairman of the committee shall preside over the hearing in accordance with the rules established by the Board of Trustees.

Section 3. *Verdict.* The Ethical Relations Committee of the Board of Trustees shall hear any new and pertinent evidence any interested party desires to present, and at the conclusion of the trial the decision of the component society shall be affirmed, overruled or sent back to the component society for reconsideration.

Section 4. *Notification and right of appeal.* The secretary of the Society shall notify the defendant and the secretary of the component society wherein the defendant holds membership, of the action of the Board. In the event of a decision against the accused he shall have the right to appeal the decision to the Judicial Council of the American Medical Association and the secretary of the State Society shall so notify the accused of this right.

# CHAPTER XII. PEER REVIEW

## PART 1. COMPONENT SOCIETY PROCEDURE

Section 1. *Local Peer Review Committee.* Each component Society shall have, either by appointment or election, a Peer Review Committee whose duties it shall be to review all proper complaints and inquiries brought before it by physicians, patients, institutions, insurance carriers, or government agencies.

The district peer review committee shall function and operate on behalf of any county society which does not establish such a committee.

Section 2. The committee shall consist of a chairman and such members representing the various specialties, including family practice, as each individual county society shall determine. Such committee should have access to counsel from each of the various medical specialties. The component county society may establish reasonable rules of procedure but shall not be bound by the technical rules of evidence as the same pertains in courts of law. All proper complaints shall be reduced to writing and shall be signed by the individual making the complaint.

Section 3. Original complaints received by the Illinois State Medical Society shall be referred to the proper county society or to the district committee.

Section 4. The Peer Review Committee shall include the functions of the grievance committee, the prepayment plans and organizations committee, the mediation committee and any other committee having to do with investigations and review but shall not replace or supersede the ethical relations committee.

Section 5. The Peer Review Committee shall initiate consideration of all complaints and matters filed with it within 60 days from the date of filing and shall render an opinion within 30 days after the conclusion of the hearing. In the event the committee does not follow this procedure any party may appeal for relief to the proper district committee whose procedure shall be the same as is set forth herein for county societies.

Section 6. The Peer Review Committee shall have no disciplinary powers but instead, shall report its findings in writing to all parties involved. In the event the investigation and study of the committee results in a determination that there has been a violation of law or unethical conduct on the part of any physician, or a violation of the Constitution or Bylaws of his component society, or of the Illinois State Medical Society, or of the Principles of Medical Ethics promulgated from time to time by the American Medical Association, the matter shall be referred in writing to the component society.

Section 7. In its study and deliberations the Peer Review Committee shall evaluate acts by the standards established by the House of Delegates of the American Medical Association (specifically known as the Principles of Medical Ethics of the American Medical Association), and by such additional standards as shall be incorporated in the Consitution and Bylaws of the Illinois State Medical Society and/or the county medical society.

Section 8. Any party to the proceedings considering himself aggrieved by the findings and recommendations of the committee shall have the right to appeal through the component society to the Illinois State Medical Society.

Section 9. In the event of an appeal to the Illinois State Medical Society, the county society shall send to the Illinois State Medical Society a copy of the complaint, the exhibits and the opinions of the county or district committee. Any appeal hereunder shall be filed with the Illinois State Medical Society wihin 30 days after the final opinion of the county or district committee has been rendered.

## PART 2. ILLINOIS STATE MEDICAL SOCIETY PROCEDURES

Section 1. All appeals received by the Illinois State Medical Society shall be referred to the Council on Economics and Peer Review, which shall review opinions of the county or district peer review committee. The council shall have the power to counsel with and obtain information from medical specialists when appropriate. The Council shall have the power to review both the procedural and substantive aspects of any appeal before it.

Section 2. The council upon receiving notice of an ap-

peal shall set the matter for hearing within 30 days after the appeal has been filed and at such hearing shall review the record sent to it from the county society or district society, receive additional pertinent evidence any interested party desires to offer and render its conclusions and findings in writing, copies of which shall be mailed to all interested parties. The Peer Review Committee shall have no disciplinary powers but instead, shall report its findings to all parties involved. The conclusions and findings shall be advisory only.

Section 3. The Council on Economics and Peer Review of the Illinois State Medical Society shall include the functions of the grievance committee, the prepayment plans and organizations committee, the mediation committee and any other committee having to do with investigations and review but shall not replace or supersede the ethical relations committee.

Section 4. In the event the investigation and study of the Council results in a determination that there has been a violation of law or unethical conduct on the part of any physician, or a violation of the Constitution or Bylaws of his component society, of the Illinois State Medical Society, or of the Principles of Medical Ethics promulgated from time to time by the American Medical Association, the matter shall be referred in writing back to the component society.

### CHAPTER XIII. MISCELLANEOUS

The fiscal year of this Society shall be from January 1 to December 31 inclusive.

### CHAPTER XIV. AMENDMENTS

The House of Delegates may amend any article of these Bylaws by a two-thirds vote of the delegates present at any meeting, provided that such amendment shall not be acted upon before the day following that on which it was introduced.

### CHAPTER XV. PARLIAMENTARY PROCEDURES

For those matters not covered by the Constitution and Bylaws of the Illinois State Medical Society, Sturgis Standard Code of Parliamentary Procedure, Current Edition, shall be the guide for conduct of meetings of the House of Delegates, Board of Trustees and all councils and committees.

## Index to Constitution and Bylaws


Ad Hoc Committees
House of Delegates ....212
Board of Trustees ....213
Advisory Committee to Auxiliary ....213
Affiliate Societies
Council on ....210
organization ....211
Amedments
to the Bylaws ....216
to the Constitution ....205
American Medical Association
membership ....205
Annual Dues, Assessments ....206
Audit and Financial Statement ....210
Benevolence Fund ....210
Board of Trustees
committees ....212
composition ....208
duties ....209
election by House of Delegates ....208
election of Chairman ....209
meetings ....209
organization ....209
powers of ....213
quorum ....209
term of office ....213
vaconies ....209
Bonding of officers and employees ....209
Bylaws ....205
Changes in the Constitution and Bylaws Committee ....211
Committees ....210
structure ....210
councils ....210
organization ....211
House of Delegates ....211
Board of Trustees ....212
Component Societies ....205
Composition of the Society ....205
Constitution ....205
Constitution and Bylaws, Committee on ....211
Conventions and Meetings ....205
House of Delegates ....207
Councils (standing committees)
organization of ....211
reports ....211
terms of office ....211
vacancies ....211
County Societies, Organization of ....213
Credentials Committee ....211
Discipline
Component Society Procedure ....214
State Medical Society Procedure ....215
District Committees ....210
Dues, Funds, and Assessments ....206
Economics and Peer Review, Council on ....210
Education and Manpower, Council on ....210
Education ond Scientific Programs ....207
Election of Officers ....208
Ethical Relations Committee ....212
Executive Administrator ....209
Executive Committee ....212
Finance and Medical Benevolence Committee ....212
Governmentol Affairs, Council on ....210
House of Delegates
composition ....207
delegates ....207
district divisions ....207
meetings ....207
order of procedure ....207
term of office ....208
House of Delegates Committees ....211
organization ....212
Medical Service, Council on ....210
Membership
associate members ....206
discriminotion of membership ....206

distinguished members ....206
emeritus members ....206
in-training members ....206
regular members ....205
retired members ....206
service members ....206
student ....206
tenure and termination of membership ....206
Officers
elections ....208
duties ....208
terms of office ....208
Medical-Legal Council ....210
Mental Health and Addiction, Council on ....210
Miscellaneous ....216
Parliamentary Procedures ....216
Peer Review
Component Society Procedures ....215
State Medical Society Procedure ....215
Planning and Priorities Committee ....211
Policy Committee ....212
Publication Committee ....212
Public Relations and Membership Services, Council on ....210
Resident Physician Section ....207
Reference Committees ....211
Rules and Order of Business Committee ....211
Seal, the ....205
Student Business Session ....207
Tellers and Sergeants-at-arms Committee ....211
ISMS Auxiliary, Advisory Committee to ....213



# 1978-1979
# Policy Manual of the Illinois State Medical Society

"Policy statements shall be defined as guidelines for the management of the Illinois State Medical Society affairs, based upon prudence, sound judgment and experience."

"Rules and regulations may be prepared by the Board of Trustees or by committees, for use in the implementation of policy."

This manual shall be a guide for officers, trustees, committee chairmen and headquarters staff to the stand taken by the House of Delegates of the Illinois State Medical Society on all issues involving Society policy.

Its statements shall combine and reconcile the best expressions made on all phases of policy involving the House of Delegates, the Board of Trustees and the various committees.

All policy statements (except those involving the funds of the Society) shall have the approval of the House of Delegates, since the Constitution and Bylaws provide in ARTICLE V:

"The House of Delegates shall set the basic policy and philosophy of the Society."

All policy statements developed during the interval between meetings of the House shall be submitted at its next meeting for action. The House may:

(1) approve, amend, or reject—
(2) refer the statement to the Board for reconsideration and subsequent report—
(3) remand the statement to the committee from which it came for further study and report.

Policy statements for the consideration of the House must be presented in resolution form. A member of the Illinois State Medical Society may propose policy by requesting any delegate to submit an appropriate resolution. The Policy Committee will develop policy statements from actions of the House of Delegates and, after approval by the Board of Trustees, the statements will be published in this Policy Manual.

Temporary policy between meetings of the House is determined by the Board. Committees may request Board consideration at any time.

The Illinois State Medical Society shall support policy statements approved by the House of Delegates of the American Medical Association.

National policy is the prerogative of the national association. Until specific contrary action emanates from the AMA House of Delegates, the Board of Trustees and the officers of the ISMS shall consider all such policy as binding.

Policy action at the state level does not rescind official AMA rulings in Illinois.

The same "chain of command" should exist between the county medical society and the ISMS House of Delegates. Policy established at the State Society level must prevail until majority action by the House of Delegates has rescinded or reversed the statements. This represents "majority rule" and must be followed closely to preserve the democratic process.

## PROFESSIONAL POLICIES

### Abortion

The decision to perform an abortion is a medical matter to be determined by agreement between the patient and the physician. Performance of abortions should be carried out in accordance with current guidelines as promulgated by the House of Delegates. If not in conflict with state and federal law, an abortion so performed shall not be considered unethical. No physician shall be required to perform or participate in an abortion.

## Acupuncture

Acupuncture is a surgical procedure and its practice should be limited to physicians licensed to practice medicine in all of its branches and to dentists.

## Alcoholism

Alcoholism is an illness characterized by preoccupation with alcohol and loss of control over its consumption such as to lead usually to intoxication if drinking is begun; by chronicity; by progression, and by tendency toward relapse. It is typically associated with physical disability and impaired emotional, occupational and/or social adjustments as a direct consequence of persistent and excessive use of alcohol.

Insurance companies are encouraged to include appropriate coverage for alcoholism in health insurance policies similar to coverage for any other illness and general hospitals, both public and private, are encouraged to accept alcoholic patients (both in-patient and out-patient) for detoxification and rehabilitation.

## Alcoholism Education

The Illinois State Medical Society supports the concept that medical schools and hospital training programs should expand instruction of students in the treatment of acute and chronic alcoholism, as well as its cause and prevention; that mental health clinics should enlarge their services to include treatment and counseling of alcoholics and their families and, where appropriate, collaborate with Alcoholics Anonymous as well as half-way houses; that education programs aimed at alcohol abusers who are drivers should be encouraged and legal restrictions established to prevent them from holding drivers' licenses; that education of the public (at all age levels) regarding the nature of alcohol and its physiologic and psychologic effects should be encouraged.

## Ambulance Services

All ambulance services should meet minimum standards as developed from time to time by the Illinois State Medical Society and the State of Illinois.

## Athletic Programs

Children of school age, through the 9th grade, should not participate in body contact sports.

Elementary school children develop better physically if activities are informal and not highly competitive.

Medical supervision of all athletic programs is essential.

## Audits & Surveys (Hospital, nursing homes, etc.)

Audits and surveys which impinge on personal privacy, patient care and local hospital trustee and medical decisions as to management should not be condoned.

## Birth Control

The preventive medicine approach to the problem of unwanted pregnancies should be encouraged through family life education in the schools, wider dissemination of family planning information, including birth control information and devices, and encouragement of research in population control methods.

## Blood Procurement

Inasmuch as blood procurement affects the entire community, any blood procurement program should be carried out only with the approval of the local county medical society involved.

## Communicable Diseases

Physicians, especially those engaged in public health work, should enlighten the public concerning all regulations and measures for the prevention and control of communicable diseases. When an epidemic prevails, a physician shall continue his labors without regard to his own health.

## Community Health Week

The medical profession shall provide the scientific leadership to focus attention on the health needs of the community and to encourage and assist in developing Community Health Week activities during the winter or spring of the year.

## Comprehensive Health Planning

Upgrading of local health facilities should be implemented through Comprehensive Health Planning on a home rule basis rather than through metropolitan oriented advisory services. Where a county medical society is unable to enter into meaningful participation in areawide health services planning, this function may be assumed by an appropriate ISMS District Committee or, where the appropriate District Committee is unable to act, by the Illinois State Medical Society.

## Confidentiality

Communications received in confidence by physicians from patients are privileged: the privilege is that of the patient and the physician is the guardian of the privilege and must not betray it. Current day social values dictate that privileges must be continued in accomplishment of the treatment of human illness. Section 9 of the Principles of Medical Ethics states that "A physician may not reveal the confidences entrusted to him in the course of medical attendance, or the deficiencies he may observe in the character of patients, unless he is required to do so by law or unless it becomes necessary in order to protect the welfare of the individual or the community." The Illinois State Medical Society re-affirms its belief in this principle and supports activities to guarantee continuation of privacy, while recognizing the need for collection of statistical data and enforcement activities in the public good.

The Illinois State Medical Society supports the concept of the confidentiality of the doctor-patient relationship as it relates to the ambulatory patient record and will take an active role in uncovering any violation of the doctor-patient confidential relationship by officials and personnel of review organizations and will take whatever steps are necessary to eliminate the breach of confidence.

ISMS is in total opposition to the use of the Social Security number as a universal number identifier.

## Conflict of Interest

When a case of conflict of interest arises and is self-evident, by the attitude shown by the individual concerned, it should be referred to the Executive Committee of the Board of Trustees of the ISMS for consideration.

## Continuing Education

Continuing education shall be one of the basic purposes of the Illinois State Medical Society for scientific advancement, humanization of medicine, improvement of medical public relations, and development of cooperation and rapport with the public. The Society should continue to support the multi-faceted approach to continuing medical education as now endorsed by the Illinois Council on Continuing Medical Education.

ISMS should continue to support the efforts of county medical societies in becoming certified for sponsoring continuing medical education programs meeting the requirements promulgated by the Liaison Committee on Continuing Medical Education and the regulations of the State of Illinois.

All members should be encouraged to participate in the AMA Physician Recognition Award, as presently constituted, or its equivalent.

In the certification of educational quality of continuing medical education programs, the Illinois State Medical Society should have a primary role. Physicians should be encouraged to participate in self-assessment test programs prior to registering for such hospital courses and other learning activities.

Sponsors of continuing medical education courses should provide full disclosure of materials, methods, objectives and evaluation procedures of offered courses.

## Cultists, Association with

The Judicial Council of the American Medical Association has ruled that it is unethical to associate VOLUNTARILY with an individual who practices as a member of a "cult."

## Current Procedural Terminology

The Illinois State Medical Society endorses the American Medical Association's Current Procedural Terminology and encourages its use by Illinois physicians.

## Death, Legal Definition of

ISMS will not support any legislative proposal which seeks to define death unless it provides that, based upon usual and reasonable standards of medical practice, death has occurred when it is determined by a doctor of medicine that a person has experienced the permanent and irreversible cessation of the integrated functioning of the respiratory, circulatory and nervous system, according to the following standards:

(a) the irreversible cessation of spontaneous respiratory and circulatory functions; or

(b) if artificial means of support preclude reliance on item (a), the irreversible cessation of spontaneous brain function, which may be confirmed by a flat (isoelectric) electroencephalographic tracing in the absence of hypothermia and of barbiturate and other nervous system depressants.

## Death With Dignity

The Illinois State Medical Society will continue to oppose death with dignity, right-to-die and similar legislation, based on what must necessarily be a private matter between physician and patient.

## Disaster Control

Any disaster creates an obvious need for trained personnel to aid the sick and injured. Local medical societies should cooperate to provide medical self-help programs. County societies should provide training for their membership in the treatment of mass casualties, radiological casualties and in the organization, operation and maintenance of emergency hospitals.

## Discrimination—(see "Freedom of Choice")

## Drugs, Prescriptions

Prescription drugs may be dispensed only upon the authorization of a physician licensed to practice medicine in all its branches. Public health departments should not conduct drug dispensing and distribution programs without direct physician supervision of patients receiving medication.

Substitution of prescribed drugs by pharmacists is opposed, except in cases of extreme emergency, unless there be full explanation and agreement by both the patient and the doctor.

The package insert labeling pharmaceutical preparations is a guide for the clinical application of the product and should not be used as an absolute standard limiting the practice of medicine.

## Electromyoneurographic Procedures and Examinations

Clinical electromyoneurographic procedures and examinations, which inherently involve medical interpretations, descriptions of findings, and rendering of diagnostic opinions, should be performed only by physicians licensed to practice medicine in all its branches and trained in these procedures.

## Ethics

Cases involving ethics shall reach the state society level only by means of an appeal. As outlined in the Bylaws, the state society committee shall serve only as an appellate body to review such cases.

## Examinations

All physical examinations should be performed in the physician's office. No examinations should be conducted on a group basis unless authorization has been given by the local county medical society in a single instance or for a specific purpose.

This general statement does not apply to the industrial or occupational health physician in his in-patient activities.

## Experimental Medical Procedures

In order to conform to the ethics of the American Medical Association, three requirements must be satisfied

in connection with the use of experimental drugs or procedures:

1. The voluntary consent of the person on whom the experiment is to be performed should be obtained.
2. The danger of each experiment must be previously investigated by animal experimentation.
3. The experiment must be performed under proper medical protection and management.

## Eyes

Only physicians licensed to practice medicine in all its branches are qualified to prescribe or use eye medications; only such physicians should continue to be the primary entry-point for eye care. ISMS will vigorously oppose any attempt in Illinois to give optometrists a license to prescribe or use medications or to serve as a primary entry-point in the provision of eye care.

## Fee Schedules

No member or committee shall be permitted to approve a fee schedule for the Illinois State Medical Society until it has been submitted to and approved by the House of Delegates or the Board of Trustees. Fees should be commensurate with services rendered.

## Foundations for Medical Care

The Illinois Foundation for Medical Care is a not-for-profit corporation established to provide physicians with leadership roles in modifying health care delivery in their communities, thus assuring quality care at reasonable cost.

The Illinois Foundation for Medical Care is completely accountable only to the House of Delegates, through the Board of Trustees of ISMS, and to each component society of ISMS.

Establishment of autonomous county and/or multi-county foundations under the sponsorship of local medical societies is encouraged and, together, local and state foundations shall provide a mechanism through which foundation-sponsored programs can be developed and administered throughout the state.

The Illinois Foundation for Medical Care is authorized to investigate and, if economically feasible, to implement programs for supporting physician organizations endorsed by constituent medical societies. Such support is to be in the areas of data needs and other specialized activities, such as statewide co-ordination, statistical analysis, co-ordinated negotiations and support of related state level organizations, utilizing public, governmental or private funds to reimburse the foundation for such activities. Specifically, the IFMC Board is authorized to investigate the feasibility of becoming a statewide support center for physician organizations endorsed by constituent medical societies and to provide administrative support, data processing and specialized services to such physician organizations.

## Freedom of Choice

The mutual right of physicians and patients to exercise freedom of choice in medical matters shall be maintained. This includes the right of the patient to choose the physician by whom he will be served, and the right of the physician (except in emergencies) to a corresponding freedom of choice. All members of the Illinois State Medical Society enjoy the same rights and privileges and are bound by the same obligations and standards of professional conduct.

ISMS supports the concept of second opinion—only via the usual and customary referral pathways guaranteeing the free choice of physicians.

## Governmentally Supported Health Facilities

ISMS should not facilitate the development of governmentally-supported Health Maintenance Organizations or similar practice alternatives which would be discriminatory against the private or group practice of medicine.

## Health Care—Ancillary Services

All segments of our population are entitled to and shall receive the best health care available. The physicians in Illinois are encouraged to cooperate in the implementation of any national program meeting with the general policy statements of the Society. (This shall be interpreted to include health aspects in nursing home care, use of recreational facilities, environmental health, public health, employment problems, problems of migrant workers, etc., and any other area which involves the health of the people of this state.)

## Health Care Costs

The public should be educated concerning the difference between "health care costs" and "medical care costs." Members of the profession should cooperate with the various ancillary groups and should be able to explain the cost factors involved in total care.

ISMS encourages its members to be aware of the cost of hospital services, supplies and drugs and encourages physicians to receive and review the hospital bill of each patient he hospitalizes as a voluntary step toward cost containment of health care.

ISMS is unalterably opposed to governmental control of hospital costs and physicians' fees and reaffirms its faith in the private enterprise system which has made the United States great and strong and which seeks to make health care available to everybody.

The Illinois State Medical Society encourages cost sharing by patients in all medical care reimbursement plans.

## Health Careers

All capable and worthy individuals interested in medicine as a career shall be encouraged and assisted by the Illinois State Medical Society. Those interested in paramedical fields shall be provided with all pertinent information.

## Health Insurance, Governmental Programs

The Illinois State Medical Society is opposed to compulsory governmentally-mandated national health insurance plans and will continue to point out its dangers and disadvantages to the public, including those in which

quality of care is compromised.

Governmental health insurance benefits for mental illness should be comparable to benefits for any other medical condition.

Governmental health insurance programs providing reimbursement for medical services under the direction of practitioners other than doctors of medicine or osteopathic medicine should establish a separate category for such reimbursement, with separate payment, and be optional to the insured.

ISMS will actively oppose any state or federal legislation which proposes reimbursement under health insurance programs of psychologists, social workers or any group of individual practitioners without medical supervision.

## Health Insurance, Voluntary Plans

ISMS endorses the principle of voluntary health insurance. Fixed fee schedules should be recognized as indemnification to the patient and not necessarily payment in full.

The Illinois State Medical Society supports the concept of increased insurance coverage for out-patient diagnostic tests.

Inasmuch as the fee coverage by insurance plans may not cover the full fee of the physician, the physician is encouraged to develop a prior agreement with the patient, such as the "Statement of Understanding." This will outline to the patient his individual responsibility for the physician's fee.

ISMS objects to third party carriers interfering with the practice of medicine and the patient-physician relationship by:

Implying to patients that physician's charges above insurance benefit allowances are excessive;

Suggesting to physicians that insurance company reimbursement amounts be accepted as payment in full;

Suggesting that physicians perform alternative surgical procedures;

Instituting utilization review of hospital patients in the private sector which by-passes local physician review mechanisms;

Discriminating against the physician who does not have a separate contractual relationship with the carrier and inhibiting the patient's free choice of physician.

ISMS endorses long-held principles that:

A contractual relationship that exists between a patient and a third party does not involve the physician (unless the physician has agreed to such involvement); and

The third party is not involved in the contract existing between the patient and his/her physician (unless such involvement has been agreed to by both patient and the physician).

## Health Screening by Paramedical Personnel

Health evaluation, to be adequate, must include a physical examination only by or under the direct supervision of a physician licensed to practice medicine in all of its branches with physician interpretation of the appropriateness and reliability of various screening procedures used.

## Hearing Disorders

Physicians licensed to practice medicine in all its branches remain the primary entry point for the care of patients with hearing impairment.

## Hospitals

Physicians should sponsor and assist in the development of all medical staff committees within the hospital.

The local medical profession should cooperate to achieve the accreditation of all eligible hospitals, and should encourage the stabilization or reduction of hospital costs in all areas where they have authority.

All county medical societies are encouraged to form standing committees composed of medical society officers and representative officers of all hospital staffs in their areas to guarantee a free exchange of information between the medical society and hospital staffs related to activities of hospitals, medical organizations, governmental and quasi-governmental agencies in their community.

The Illinois State Medical Society encourages the development of local peer review plans for appropriate review of utilization of hospital emergency rooms.

## Hospital—Medical Staff—Management Relationship

Any proposal or arrangement between institutional management and medical staffs should not conflict with the Principles of Medical Ethics or abridge the property right endowed upon the individual physicians by the Illinois Department of Registration and Education. The practice of medicine is the physician's legal prerogative and responsibility. To insure the quality of medical care, each hospital has the obligation to cooperate with and assist its medical staff in implementing procedures by which the quality of medical care in that hospital may be maintained by and through its medical staff.

ISMS is opposed to hospital actions which unilaterally stipulate that professional liability insurance is a prerequisite for membership on a medical staff. If a hospital proposes to require evidence of professional liability insurance as a condition of membership on a medical staff, such condition should be in accord with rules and requirements as established by the organized medical staff of the hospital in cooperation with the hospital board of trustees. To protect their assets, members of a hospital medical staff should be assured of the adequacy (scope and amount) of professional liability coverage carried by the hospital as a reciprocal disclosure between the staff and hospitals.

Results of recertification examinations should not be the sole criterion used by hospital governing bodies and hospital medical staffs in the granting of clinical privileges.

## Hospital Records and Their Availability

Patient care hospital records contain privileged information of confidential nature. Such records are the property of the hospital; information contained therein is held in trust, through a fiduciary relationship, by the hospital.

Patients, and upon appropriate, written authorization, their attorney or succeeding physician, have the right of access to these records, with the ability of review and the right to copy or receive copies. This access is not afforded to patients in cases of psychiatric illness.

Upon receipt of proper, written authorization from the patient, a copy, abstract or summary shall be provided as required, to insurance companies, governmental agencies, or other hospitals.

Patient records utilized by official committees of organized medical staffs to accomplish scientific studies of morbidity or mortality, utilization review, peer review or other patient care improvement activity remain confidential and shall not be disclosed to any person outside the purview of such committees.

Where litigation is involved, a physician may be required to release medical records in the absence of a signed patient authorization. In those instances, a physician should ascertain that he is required to release the medical records and that the agent so requiring the release has the appropriate authority.



## Hospital Staff Assessments

The medical staff of a hospital does not have the privilege or the right to make compulsory assessments of members of the medical staff for building funds, or to demand an audit of staff members' personal financial records as a requisite for staff appointments.

## Immunization Programs

Illinois residents should be provided access to all medically indicated immunization. Physicians are requested to provide this protection, especially to all children, or to encourage the local public health agency to perform this function.

Every school district should have a school health committee with at least one physician as a member. County advisory school health councils should assist in coordination.

County medical societies should be consulted by health departments planning any mass immunization campaign. In counties where there is no public health department, the Illinois Department of Public Health should contact either the county medical society or local physicians (whichever is appropriate) for coordination of the immunization program.

The Illinois Department of Public Health or the Illinois State Medical Society should institute whatever is necessary, including appropriate state indemnification or "exemption from liability" legislation, to assume or alter the liability responsibility during any mass immunization program.

If private facilities are utilized during a mass immunization campaign, normal reimbursement procedures may be employed, but no charge shall be made for the cost of vaccine paid for by the federal government.

## Indigent, The Care of the

Personal medical care is primarily the responsibility of the individual. When he is unable to provide this care for himself, the responsibility should properly pass to his family, the community, the county, the state, and only when all these fail, to the federal government, and only in conjunction with the other levels of government in the order above.

The determination of medical needs should be made by a physician. The determination of eligibility should be made at the local level with local administration and control. The principle of freedom of choice should be preserved.

## Laboratories

All laboratories providing medical data should be under the direct supervision of a physician.

## Marijuana

ISMS does not endorse the legalization of the possession or use of marijuana.

Since the medical and psychiatric knowledge concerning the short-term and long-term effects of cannabis is very limited, medical research should be supported by public and private resources of the State of Illinois.

## Medical Care, Provision of

Medical care shall be provided regardless of the ability of the patient to pay. Physicians shall not refuse to render needed emergency care to any patient.

## Medical Diagnosis and Treatment

Third parties, including government personnel, insurance carriers, review organizations and hospital personnel should be informed and educated that the Illinois State Medical Society endorses the concept that prognosis and length of treatment must always be individualized to the patient, rather than to the diagnosis.

## Medical Education

The Illinois State Medical Society supports development of innovative curricular and co-curricular programs in medical education maintaining a firm foundation in the basic sciences.

## Medical Examiners

ISMS favors a medical examiner system throughout the state in preference to a coronor system, wherever practical.

## Medical Psychotherapy

Medical Psychotherapy is a medical procedure for the treatment of mental and physical ailments or illness. It involves verbal and non-verbal communications with the patient, and always includes continuing medical diagnostic evaluation and drug management as indicated. Medical psychotherapy may be performed only by a physician licensed to practice medicine in all of its branches, who has had training in psychiatric medicine.

## Medical Testimony, Expert Witnesses

An expert medical witness is defined as a physician licensed to practice medicine in all its branches having a basic educational and professional knowledge as a general foundation for testimony and, in addition, having special expertise, current personal experience, practical familiarity, and technical knowledge of the problems that are

being considered, as well as alternative forms of treatment, and is currently active in the practice of the medical subject under discussion.

Any physician licensed to practice medicine in all its branches who functions as an expert witness must satisfy the definition of an expert witness, that the definition be a matter of policy, and that it be considered unethical conduct on the part of any physician appearing as an expert witness who does not meet this standard.

## Medical Testimony, Impartial

The ends of justice are served when impartial medical witnesses are available to give testimony. The ISMS supports this concept and offers its assistance in the provision of impartial medical testimony.

## Mental Health

The Illinois State Medical Society strongly opposes the double standard of care in state hospitals and favors elimination of permit physicians (unlicensed physicians practicing in state institutions). Every effort should be made to extend educational opportunities to these permit physicians to enable them to achieve full licensure.

In addition, the Department of Mental Health and Developmental Disabilities should adopt a firm policy for the continuing education of physicians employed by its various mental health centers, allocating state funds necessary to provide high-quality continuing medical education relevant to the needs of these physicians.

Each constituent county society should cooperate fully with and support local units of the Department of Mental Health in their patient care efforts, specifically seeking to encourage:

1. Local general hospitals to accept mental health patients who can be helped by short-term treatment, leaving to state institutions the responsibility for such chronic and long-term cases which local hospitals cannot presently handle.
2. Local general hospitals and practitioners to retain in their own care those geriatric patients who have ailments of primarily a physical nature.
3. Local physicians, local hospitals, and local skilled nursing facilities to provide primary and secondary care for psychiatric problems to the extent possible; given facilities and physician-time available.
4. Arrangements for emergency mental health care, i.e., crisis intervention, to be available areawide.

All physician or other health service provided to the Department of Mental Health, other than that by full-time employees, should be on the same fee-for-service basis as any other medical service which is paid by the patient or third party insurer.

Involuntary psychiatric hospital certification, initial or subsequent, must without exception remain the responsibility of a physician licensed to practice medicine in all of its branches, and a physician licensed to practice medicine in all its branches should be required to certify the discharge of any patient from a psychiatric institution.

## Minors, Medical Treatment of

Where parental consent is not legally required for medical treatment of minors, the physician's judgment shall prevail as to whether or not the parents should be notified of such treatment.

## Multiphasic Screening

Automated multiphasic health testing and screening laboratories are recognized as an extension of services available to the physician for the health needs of individual patients. A position statement on multiphasic health testing, developed by the ISMS Council on Environmental and Community Health, and the American Medical Association Guidelines for establishing and operating such programs are attached as an appendix to the Policy Manual.

## Nurses—Shortage

A severe shortage of graduate nurses continues to imperil the provision of quality patient care. The ISMS supports all forms of qualified nursing education and urges that all such schools be encouraged to remain in operation.

## Nursing Homes

Every patient receiving long-term nursing care should have an attending physician who acknowledges his continuing responsibility in writing. Responsible parties, preferably the patient or immediate family, should be urged to select a physician.

## Nutrition

Prophylactic use of iron fortified foods is approved in accordance with a 7-point statement developed by the Nutrition Committee and the Council on Environmental and Community Health in 1971.

## Occupational Health

Occupational health is an essential ingredient of employee welfare. The adoption and development of health programs in industry should be encouraged.

Occupational health will be advanced through the utilization of industrial physicians.

## Optometric Services

ISMS supports the concept that those performing optometric services in Veterans Administration facilities should be directly responsible to their respective departments of ophthalmology.

## Osteopaths, Association with

Voluntary professional associations with a Doctor of Osteopathy are not deemed unethical if the Doctor of Osteopathy bases his practice on the same scientific principles as those adhered to by members of the American Medical Association and if he is licensed to practice medicine and surgery in all of its branches in Illinois.

## Peer Review

Peer review is the evaluation by practicing physicians of the quality, appropriateness and efficiency of services

ordered or performed by other practicing physicians. It is the all-inclusive term for medical review efforts, including utilization review, quality of care, competence determination and ethical considerations.

Medical society peer review shall be conducted at the local level whenever possible.

## Physician-Patient Relationship

All committees dealing with the review of physician-patient relationship in hospitals and nursing homes are urged not to release findings to any third parties except by subpoena or court order. Any reports issued by the committees involved should be submitted to the chief of staff for his disposition.

## Physicians

The term, "Physician," may only be applied to one who has equivalent qualifications of a "physician licensed to practice medicine in all its branches." The goal of the Illinois State Medical Society is to have this definition made a part of the Illinois Medical Practice Act.

## Prepayment Plans and Organizations

It is not within the province of ISMS to act in other than an advisory capacity when working with a "third party plan," and its best efforts should be directed toward supplying guidance, education and communications between the membership and the prepayment plans and organizations involved.

The principle of free enterprise as exemplified by private insurance companies and the "Blue" plans is to be endorsed.

Such plans should recognize that free standing medical and surgical facilities are acceptable methods of delivering high quality health care. Reimbursement for expenses incurred as an outpatient in such facilities should be included in the benefits of these plans.

ISMS is opposed to any legislation which mandates insurance benefits for medical care of psychiatric illness into an optional status.

## Prolonging Human Life

Any legislation which proposes statutory restrictions that can intrude into the relationship of the physician and his patient and which may interfere with the physician's ability to use his best judgment and training in caring for his patient is not in the best interest of either the patient or the public and should, therefore, be unrelentingly opposed.

## Psychosurgery

Psychosurgery refers to those surgical operations which irreversibly destroy brain tissue for the primary purpose of treating mental disorders. Psychosurgery does not include procedures undertaken to treat definable disease states such as tumors, epilepsies, aneurysms and chronic pain syndromes, nor does it include electrical stimulation of the brain, such as electroconvulsive therapy. Psychosurgery should not be performed without adequate documentation of indications, adequate consultation and reasoned consent.

## Public Aid

The "chain of command and procedure" in handling problems arising in the field of public aid shall be from the county to the state advisory committee; then the state advisory committee shall assume the responsibility of making the medical program work and cooperating with the Illinois Department of Public Aid to maintain the best type medical care for the recipients of state aid.

The fees paid by the state/federal programs to physicians shall be based upon the usual and customary fee concept.

An extensive program of education should be conducted for the recipients of public aid. This should include the intelligent handling of all monies provided.

Rehabilitation of all recipients should be of paramount concern.

## Public Health Departments

Public Health is the art and science of maintaining, protecting and improving the health of the people through organized community efforts, including contributions by voluntary health associations, medical societies and other health-oriented groups.

Full-time modern local health departments adequately financed and staffed at the county or multiple county level are highly desirable and if available, would be capable of providing these services to the people throughout the state. It is of paramount importance that such departments should be established where none now exist and that county medical societies, as well as physicians, should give their wholehearted support.

Local public health service jurisdictions should be consolidated into sufficiently large geographic and population districts to achieve program efficiency.

## Public Safety

Motor vehicle operators should be licensed on the basis of the applicant's physical and mental capacity to operate such a vehicle safely.

## Rehabilitation

All physical rehabilitation activities should be prescribed by a physician and the treatment carried out under the supervision of a physician.

Medical societies should render assistance to public and private agencies regarding rehabilitation facilities to be used and in the selection of patients for these services.

Insurance carriers should be encouraged to include rehabilitation services in their contracts.

## Relative Value

The Relative Value Study is not a fee schedule and is to be used for information only. All fee payments should be based on the usual, customary and reasonable concept.

No co-efficient shall be established at the state level. The

data contained in the study may be used by the ISMS, its committees or by any county medical society.

The study should be revised at appropriate intervals upon recommendation of the Relative Value Committee with approval of the Board of Trustees.

Upon request, copies may be furnished third party purveyors of health care services.

### Smoking

The Illinois State Medical Society is opposed to the sale of tobacco and tobacco products in hospitals and will encourage medical staff action to make hospitals tobacco smoke-free.

### Specialty Society Representation on ISMS Councils

For the improvement of communication and the discussion of problems of mutual interest and concern, closer liaison between specialty societies of medicine and the councils of the Board of Trustees is desirable. Representatives to serve in this capacity may be nominated by the specialty society, approved by the Board of Trustees of ISMS, and designated as consultants to the council without vote, in compliance with the Bylaws.

### Third Party Intrusion Into Medical Judgment

Medical judgment and decision-making power of the treating physician must not be abrogated by third party payors. ISMS is opposed to any third party having the power of decision as to medical necessity of services and supplies, including hospitalization, over and above the judgment of the treating physician.

### Veterans Administration

It is our belief that a Veterans Administration hospital should admit only those patients with service-connected disabilities, except in those instances where the veteran is financially unable to pay for his medical care and hospital services, as shown by a means test.

### Violence

The Illinois State Medical Society opposes the ready accessibility to hand guns without evidence of responsibility on the part of the possessor and urges strict enforcement of present federal, state and city laws and that the courts, as well as the legislature, impose maximum penalties on all offenders.

The Illinois State Medical Society will continue to take an active interest in the apprehension and prosecution of those persons committing assaults on physicians, including the offering of rewards and other incentives in the solution of such cases.



## ADMINISTRATIVE POLICIES

### AMA-ERF

The Illinois State Medical Society's dues billing form shall include the names of all medical schools in Illinois so that every member may designate which school is to receive his AMA-ERF contribution.

### Assessments

Compulsory assessments of members of hospital staffs for any purpose are unethical and improper.

### Autonomy of County Medical Societies

In all areas, the county medical society shall be autonomous, except that no ruling by any county medical society shall conflict with the Principles of Medical Ethics of the American Medical Association or with the Constitution and Bylaws of the Illinois State Medical Society.

### Birth Certificates

Birth certificates should contain only such items as are pertinent to their function. Information recorded on birth certificates should not be provided to organizations or individuals for other than approved purposes.

### Budgets–(see "Financial Policies")

### Committee Appointments

The chairman of the Board of Trustees and the officers of ISMS shall give the trustees an opportunity to recommend physicians from their districts for appointment to various committees. Trustees shall receive the proposed list of committee appointments for their consideration and review prior to the meeting of the Board at which the final committee personnel is to be approved.

Elective committees should serve for uniform terms of office–preferably three years. These terms of office should be held on a staggered basis to provide continuity in the committee structure. Individual tenure on any committee should be limited to a maximum of nine years of continuous membership–whether elected or appointed.

Physicians appointed to an Illinois State Medical Society committee must be members in good standing of this Society.

### Constitution and Bylaws

Final copy of any changes made by the House of Delegates in the Constitution and/or the Bylaws shall be prepared for publication by the Committee on Constitution and Bylaws, in consultation with legal counsel, making sure that the published changes reflect the thinking expressed by the action of the House.

## Co-operation with the American Medical Association

Actions of the AMA House of Delegates are binding upon its membership at all levels, county, state and national.

(Since all members of the Illinois State Medical Society are also members of the American Medical Association, this is universally true in Illinois. The right to disagree, the right to protest, the right to become "the loyal opposition" is not questioned. However, until such time as the AMA House has reversed its decision, it is mandatory that the membership abide by the will of the majority.)

## Dues, Recommendation of the Board to the House

The chairman of the Board of Trustees shall place the question of dues for the coming year on the agenda for consideration by the Board of Trustees in time for the Board to present its recommendations to the House of Delegates each year.

Immediately following this meeting, written notice of the recommendation regarding dues for the next fiscal year shall be mailed to all delegates and alternate delegates from the component societies, and also to all presidents and secretaries of county medical societies. This recommendation shall also be published in the *Illinois Medical Journal* as a part of the annual report of the Chairman of the Board.

## Education, Primary and Secondary

Primary and secondary education is a community problem. In order to retain jurisdiction of these grade schools, finances should be raised by taxation at the local level.

## Election of AMA Delegates

Delegates to the American Medical Association should almost without exception be elected from those having served first as alternate delegates.

## Facility Medical Boards (Physicians)

In all legislation which establishes boards for the administration of medical facilities operated by governmental units, at least one-third of the board should be physicians licensed to practice medicine in all its branches.

## Federal Funds

When a federal government assistance program is essential it should be conducted under the administration and control of local government. The Society does not favor any federal assistance program which removes administrative control from the state or local level.

## Financial Policies

(1) The Finance Committee is to make budgetary recommendations to the Board of Trustees.

(2) The expenses of any duly elected delegate or alternate delegate attending the meetings of the House of Delegates of the American Medical Association shall not be assumed by the ISMS until he enters his official term of office set by the Constitution and Bylaws of the AMA.

(3) ISMS funds used by members campaigning for election as AMA officers, trustees or members of councils or committees must be approved by the ISMS Board of Trustees before such funds are spent for election campaign purposes.

(4) The expenses of any official representative of the ISMS attending any authorized meeting shall be determined by the Finance Committee and approved by the Board of Trustees.

(5) Any new project authorized by House action requiring the expenditure of funds must be accompanied by an estimate of the cost and suggested methods of providing the necessary funds.

(6) Budgets submitted to the House by the Board should provide for the ensuing fiscal year.

(7) In addition to fixed reserves, the development of a contingency reserve is desirable.

(8) All financial records shall be available at headquarters office, and may be examined by any member of the Society. A semi-annual summary of the financial statements of the Society shall be mailed to any county society secretary or delegate if requested. A projected budget for the next fiscal year shall be mailed to the members of the House of Delegates at least 30 days prior to the annual convention. These reports shall be in the format customarily used in ordinary corporate practice.

## Honoraria For Officers

The Finance Committee is instructed to evaluate annually the honoraria paid to ISMS officers and to recommend appropriate changes to the Board of Trustees for consideration and action, reporting any changes to the House of Delegates at its next session.

## House of Delegates, Special Meetings of

When a special meeting of the House of Delegates is scheduled which may involve an increase in dues or a special assessment, the call for that meeting shall contain specific notification of that possibility.

## Individual Rights

Since this Society believes that a strong America is a free America, the rights of an individual, or a group of individuals, to openly express themselves cannot be condemned even if one is in complete disagreement, if the laws of the land are not violated. To support such condemnation would be inconsistent with this Society's basic philosophy.

## Informing the Membership

The membership of the Illinois State Medical Society shall have been properly informed when the following items have been accomplished:

1. Official notice in the *Illinois Medical Journal*;
2. Brief notice in Action Report, outlining the issue and calling attention to the *IMJ* article; and
3. A letter is sent to all county society presidents, secretaries and county executives.

## ISMS Auxiliary

Projects in which the Auxiliary participates shall be approved by the local county medical society.

Requests for cooperation between the Auxiliary and the Illinois State Medical Society should be channeled through the Advisory Committee provided by the Board of Trustees.

## ISMS Candidates for AMA Positions

Selection and/or endorsement of ISMS candidates for positions on AMA Board, councils and committees should be submitted to the American Medical Association by the ISMS Delegation, through its chairman, after consultation with the ISMS Board of Trustees or its Executive Committee, except in situations wherein positions suddenly become open, and such consultation is impossible.

## Journal Publications

The Publications (Journal) Committee, with the approval of the Board of Trustees, has authority over the publication policy and the screening of all advertisers and advertising copy appearing in the *Illinois Medical Journal.*

## Lay Employees' Functions

Policy is established by the House of Delegates.

Staff shall cooperate with officers and committee chairmen in setting up activities and in carrying out all necessary routine.

Staff also shall keep new officers and committee chairmen aware of policy statements, and assist them in the preparation of reports to the House of Delegates to:

change existing policy

establish new policy

request House approval of committee projects and/or procedure involving policy.

Committees shall be informed of their right to set up operating rules and regulations.

## Legal Counsel

The legal counsel of the Illinois State Medical Society shall concern himself with official inquiries from officers, trustees, committee chairmen and county medical societies. Such inquiries shall be channeled through the Executive Administrator.

## Legislation

All matters pertaining to state or federal legislation shall be referred to the Governmental Affairs Council for consideration and recommendation prior to Board of Trustees and/or House of Delegates action.

Matters pertaining to federal legislation shall be checked against recommendations or policies of the American Medical Association by the Council on Governmental Affairs of the Illinois State Medical Society prior to making a recommendation either to the Board of Trustees or to the House of Delegates.

Before any legislation is developed for presentation to the Illinois General Assembly, the proposed law shall be considered by the Council on Governmental Affairs which shall work in close cooperation with any other Society committee involved. The instigating committee should determine the content of the law and the Governmental Affairs Council primarily should consider relationship of the proposed legislation to the total legislative program.

Any Council or Committee recommending legislation to the attention of the Governmental Affairs Council must provide expert witnesses when called upon to testify before Senate and House Committees in support of, or in opposition to, the legislation recommended by the Council or Committee.

## Legislative Intrusion into Medical Judgment

The Illinois State Medical Society opposes any and all legislative efforts to interfere with physicians' judgment as to which procedures are appropriate and in the best interest of his or her patients and ISMS will work aggressively to oppose any legislation abridging the physician's prerogatives in this regard.

## Mailing List

The use of the mailing list of ISMS members must be approved by special action of the Board of Trustees.

## Medical Representation in Government Planning

In health programs financed by government funding in an Illinois community, there shall be representation at the highest policy level by an official representative of the State Society and the appropriate county medical society involved. Remuneration for services in above programs shall follow the policies of the Illinois State Medical Society.

Only those programs which have involved physicians at the local level in the planning and development stages shall be approved by ISMS.

Unless physicians appointed to the boards and committees of other organizations, such as local Comprehensive Health Planning "b" agencies, are nominated by their local county medical society, such physicians shall not be considered "representative" of the medical community.

## Medical Schools

The Illinois State Medical Society favors admission of students into medical schools on the basis of their ability to be good medical students and physicians.

## Membership in Paramedical and Service Organizations

Membership in Chambers of Commerce (city, state and national) is to be encouraged. This policy extends to the individual physician as well as to the component societies.

The Society recommends that physicians affiliate with service clubs, local political action groups and participate to the fullest extent possible in affairs affecting the health and welfare of the residents of Illinois.

## Membership of Osteopathic Physicians in ISMS

Osteopathic physicians who meet all qualifications for membership, base their practice on the same scientific principles as those adhered to by members of the AMA, and are licensed to practice medicine in all its branches in Illinois, may be accepted as active members by the county medical societies throughout the state, and be accorded all privileges of full membership at the county and state levels and be so reported to the American Medical Association for acceptance at that level.

## Placement Service

Before the Physicians' Placement Service recommends that a town in Illinois be listed as needing a physician, it shall be established that the need actually exists; that the community can support a physician; that certain

physical assets (office—home—schools, etc.) are available for the physician and his family.

The qualifications of the physician also shall be ascertained prior to furnishing him with the list of available areas in Illinois needing a physician.

## Policy Statements

Policy statements shall be defined as guidelines for the management of the Illinois State Medical Society affairs, based upon prudence, sound judgment and experience.

Rules and regulations may be prepared by the Board of Trustees or by committees, for use in the implementation of policy.

## Polls, Opinion

The Board of Trustees is responsible for ascertaining the opinion of members on critical issues facing the society. Periodic membership opinion polls should be considered as one means of ascertaining member opinion. However, the vote of the House of Delegates shall express the opinion of the majority of the Illinois State Medical Society membership since delegates are the duly elected representatives of their county medical societies and it is the responsibility of the delegates to determine the thinking of their constituents so that their voting will express this opinion. The majority opinion is expressed in the House of Delegates and it should be unnecessary to conduct a membership poll except under very exceptional conditions.

## Press

All county medical societies should be encouraged to cooperate with the local press. The public should be provided with prompt and accurate information in all health fields; the source of this information should be the medical profession.

County medical societies should provide information at the local level; the State Society is responsible for press releases involving State Society officers or any official statements of the Society appearing in the press.

A code of ethics applicable to medicine and the fourth estate should be developed. (That used in the Decatur area has been given national recognition by the AMA.)

## Professional Liability

The Illinois State Medical Society endorses the concept of effective peer review in all matters related to the professional liability of physicians including the right of individual physicians to appear before appropriate peer review committees responsible for his liability insurance coverage.

The Illinois State Medical Society should protect the interests of its members by encouraging the provision of a guarantee of due process in the bylaws of the Illinois State Medical Inter-Insurance Exchange.

## Public Statements

Only officially designated persons may publicly speak for the society. The Chairman of the Board of Trustees, at the request of the President, shall designate ISMS spokesmen.

Spokesmen should bear in mind that, as representatives of the Society, they should refrain from expressing their personal views. Their public statements should be—to the best of their ability—in consonance with the Society's policies and positions.

## Publication of Research Data

In releasing research material for publication in the *Illinois Medical Journal,* or any other media, extreme care should be exercised. The welfare and privacy of the patient, and the professional reputation of the physician should be of primary concern.

If any question arises, consultation with the Board of Trustees is suggested. All such inquiries should be addressed to its chairman.

## Public Affairs

No officer or member of the Board of Trustees should be permitted (during his term of office) to allow his name as an officer or a member of the Board to be used in lists endorsing candidates for public office. Naturally his right to this privilege as a private individual is not affected.

## Rebates

In conformity with the AMA Principles of Ethics, rebates of any nature to any member, county or regional medical society, are unethical. This statement on rebates was developed as a result of a letter regarding collection services. It read in part:

> "It is our policy to remit to a participating association the sum of 10 per cent of the gross book sales to its members in addition to 10 per cent of the gross commissions received from collections. A report and accompanying payment is submitted monthly from our office."

## Reference Committee Appointments

Whenever possible at least two members shall be retained on all reference committees for the following year in order to effect continuity of experience.

## Reference Service

Physician reference service shall be the responsibility of the county medical society. When any such request is received at the state society office or by any officer of the ISMS, it shall immediately be referred to the secretary of the county medical society involved.

## Resolutions

Since the relationship between the Illinois State Medical Society and other voluntary physician membership organizations is the responsibility of the Board of Trustees, the Speaker of the House of Delegates shall refer to the Board any resolutions making reference to other voluntary physician membership organizations not affiliated with ISMS.

## Stationery, Use of Official

No officer, trustee, committee chairman or staff director is to use the official stationery of the Illinois State Medical Society for personal statements of any nature. This shall pertain especially to the endorsement of any candidate for public office.

### Surveys

The Illinois State Medical Society endorses the principle of mass surveys and encourages the use of this method whenever it meets with the approval of the local county medical society.

Any new state program involving more than one county society should be submitted to the Board of Trustees for initial approval.

### Uniform Health Insurance Claim Form

The Illinois State Medical Society supports the use of the Health Insurance Claim Form developed by the AMA Council on Medical Service by all insurance carriers and physicians.

---

# Policy Manual
# APPENDIX

## Multiphasic Health Testing
## Council on Environmental and Community Health Statement

During the recent past there has been an upwelling of various automated or multiphasic health testing or screening programs. The use of the results of such testing has at times led to a false sense of security on the part of patients, whereas other programs are being foisted on the public with the view to making money with very little concern for an individual's well being. Other programs are offered as having direct, immediate and practical medical value, without review by a physician. These many concerns prompt the necessity of a position statement on the use and application of such programs.

There is a place for computer and automated multiphasic testing and screening programs as an extension of the services available to the physician as he considers each individual case. It is entirely possible that such a mechanism will enable a physician to expand his scope of operation.

Forms of automated multiphasic health testing have been used by public health agencies and centers for developmental research in epidemiology. In these programs, asymptomatic control patients have been tested. Testings have been done to establish medical priorities or case findings in communities. Other testing has been done to separate those who probably have certain characteristics from those who do not.

Occupational or industrial health programs have used testing programs for the betterment of employees' health and working conditions. Programs such as these, whether a pre-employment examination or a study to control health hazards, are not necessarily related to medical care as such. The physician in charge may or may not at the same time be the attending physician of the employee.

As far as automated multiphasic health testing programs for individuals are concerned, these programs obtain health-related data and act as data collecting sources, following a routine using technicians or mechanical and electronic devices to determine facts. In several hours a variety of tests and measurements can be made which may provide a profile of an individual's physical status. Such a profile can be of value to a physician. The testing is not diagnosis or interpretation.

Some individually oriented automated multiphasic health testing programs are operated commercially on a for-profit basis. Many of these do determine and report facts accurately. Some, however, give the appearance of encouraging individuals to be tested without a medical referral for the tests. Some indicate that when the results are compared against standards or norms the individual does not even have to see a physician. Some, in addition, perform a battery of tests which are not requested by an attending physician.

The physician's ethical responsibility is to provide his patient with high quality services. He should not utilize services of any testing program unless he has the utmost confidence in the quality of its services. He must assume professional responsibility for the best interest of the patient. As a professional man, the physician is entitled to compensation for his services. However, he should not be engaged in the commercial conduct of a testing or screening program and should not make a mark up commission or profit on services rendered by others. It is not, in itself, unethical for a physician to own an automated multiphasic facility or interest. The use the physician makes of this ownership may be unethical.

An attending physician may not receive a rebate, referral fee, or commission from a program whose facilities have been used by his patients.

An automated health testing facility is a fact finding and reporting system. It must be limited to fact finding and exclude interpretation. Findings disclosed must be interpreted only by physicians.

Offering a combination of medical and non-medical service to the public is to be avoided. The public may be confused as to what constitutes reporting a fact and what constitutes the making of a medical diagnosis.

A practicing physician may recommend multiphasic health testing where he believes it may be helpful to him in the care of his patient. Prudence dictates that the physician be selective in recommending or requiring patients to utilize the services of an automatic health testing facility and not adopt the practice of routinely requiring that all patients, or all new patients, undergo such testing. When good medical judgment suggests the desirability of such testing, the physician should explain in general the nature and purpose of the testing. The patient must be afforded freedom to choose between automated multiphasic health testing facilities, if available. Alternatives in the way of single tests should be offered patients, where possible and practical.

An individual who is tested, or a facility which conducts these tests, may neither demand that a physician accept an individual as a patient nor evaluate the tests for the individual. The physician remains free to choose whom he will serve.

A physician employed by an automated multiphasic health testing facility, in conformity with well established policies, should not dispose of his professional attainments to any corporation or to a lay body under terms or conditions which permit the sale of the services of that physician by an agency for fee, nor allow his name or the prestige of his professional status as a physician to be used in the promotion of a commercial enterprise. He should neither aid nor abet an unlicensed individual or corporation to practice medicine.

There is a responsibility for the medical society to educate the public regarding indications for and against multiphasic health testing, to educate the membership of the society regarding ethical responsibilities in these matters, and the society must be ready to assist persons or corporations that seek advice in setting up multiphasic health testing facilities.

## AMA Guidelines for Establishing and Operating Multiphasic Health Testing Programs



The following guidelines are recommended for use by physicians and medical societies in providing technical advice and assistance in the planning, development, implementation, and operation of multiphasic health testing programs:

1. Multiphasic health testing is a method of acquiring, storing, collating, and reproducing medical data on individual patients. The testing procedures are considered to be incomplete health services. Provisions must be made for a physician to interpret and evaluate this medical data base as an aid in continuing patient care.
2. The multiphasic testing program should meet applicable licensing requirements and be appropriately evaluated for quality control.
3. Physicians must be involved in the planning and development of testing programs.
4. The operation of all MHT programs must be supervised by qualified physicians at the testing center, particularly in regard to any abnormal findings, and these physicians must see that the patient is instructed to obtain medical advice for significant abnormal findings.
5. The system should be designed to make maximum use of allied health professionals and should utilize technical and automated techniques where justified.
6. For professional value and economic feasibility, the program should include tests that are simple, safe, easy to interpret, inexpensive and quick to perform, and that have acceptable sensitivity, specificity, high predictive value, and patient acceptance.
7. The testing system should include the following criteria: reliability, accuracy of output, saving of time of physicians and allied health personnel, adequate utilization, and sufficient flexibility for customization to physician and patient needs. The program should establish individual ethnic, geographic, and other variations of normal and abnormal patterns.
8. The program should provide for confidentiality of patient data.
9. The testing program should be used, where feasible, to meet otherwise unmet community health needs and should be integrated into the continuing health care system.
10. The testing program should be designed to meet various objectives such as diagnostic services, health maintenance, and guidance in management of ongoing illness including chronic disease.
11. Evaluation methodology should be built into the program to determine the acceptance and use, yield, false positives and false negatives, as well as the long-term effects of the program on illness and the need and demand for health services. The program should include a documented accounting system, at least for internal use, and a reasonable cost finding system that would allow for cost analysis and cost summaries.
12. The program should maintain freedom of choice for both the physician and the patient.

---

## Statement of Understanding

*(between patient and physician)*

I agree that the determination of professional services to be rendered by my doctor and the fees to compensate him for these services are matters concerning my doctor and me. I understand that I have the primary duty and obligation to pay my doctor for his services, notwithstanding any contract I may have with any third party (be it an insurance company, employer, union, government, or the like). Neither my doctor nor I will permit any third party to determine what medical services I need or what fees the doctor should receive in return for these services. Any agreement that either of us may have with any third party shall not affect our doctor-patient relationship and the decisions relating to medical care and fees. Neither my doctor nor I, as his patient, are in any way bound by any contract the other may have with any third party.

# ISMS HOUSE OF DELEGATES

## OFFICIAL MEMBERS OF THE HOUSE WITH THE RIGHT TO VOTE

### Officers of ISMS

President—David S. Fox
826 E. 61st, Chicago 60637
President-Elect—P. John Seward
310 N. Wyman, Rockford 61101
Secretary-Treasurer—Audley F. Connor, Jr.
7531 Stony Island, Chicago 60649
First Vice President—Herschel Browns
4600 N. Ravenswood, Chicago 60640
Second Vice President—G. W. Giebelhausen
1101 Main St., Peoria 61606
Speaker of the House—Cyril C. Wiggishoff
25 E. Washington, Chicago 60602
Vice Speaker of the House—Robert P. Johnson
108 Maple Grove, Springfield 62707

### Board of Trustees

Chairman, Board of Trustees—Robert R. Hartman
1515A W. Walnut, Jacksonville 62650
1st District—John J. Ring
511 Hawley, Mundelein 60060 .....1980
2nd District—Allan L. Goslin
712 N. Bloomington, Streator 61364 .....1980
3rd District—Alfred Clementi
675 W. Central Road, Arlington Heights 60005 ..1979
Raymond DesRosiers
1044 N. Francisco, Chicago 60622 .....1980
Robert T. Fox
2136 Robincrest Lane, Glenview 60025 .....1979
Jere Friedheim
3050 S. Wallace, Chicago 60616 .....1979
Morris T. Friedell
7531 Stony Island, Chicago 60649 .....1981
Henrietta Herbolsheimer
1700 E. 56th St., Chicago 60637 .....1981
Lawrence L. Hirsch
2434 Grace, Chicago 60618 .....1981
Harold J. Lasky
55 E. Washington, Chicago 60602 .....1980
Richard N. Rovner
645 N. Michigan, Suite 920, Chicago 60611 .....1980
Joseph Sherrick
303 E. Superior, Chicago 60611 .....1980
4th District—Fred Z. White
723 N. 2nd St., Chillicothe 61523 .....1979
5th District—Paul F. Mahon
Dept. Radiology, St. John's Hospital
Springfield 62701 .....1979
6th District—Robert R. Hartman
1515A W. Walnut, Jacksonville 62650 .....1981
7th District—Alfred J. Kiessel
1 Powers Lane Pl., Decatur 62522 .....1979
8th District—James Laidlaw
104 W. Clark, Champaign 61820 .....1979
9th District—Warren D. Tuttle
203 N. Vine, Harrisburg 62946 .....1981
10th District—Julian W. Buser
6600 W. Main, Belleville 62223 .....1981
11th District—Kenneth A. Hurst
52 Bunting Lane, Naperville 60540 .....1980
12th District—Joseph Perez
5670 E. State, Rockford 61108 .....1980
Trustee-at-Large—George T. Wilkins, Jr.
27 Glen Echo Dr., Edwardsville 62025 .....1979

### Representatives of County Societies

A complete listing of delegates and alternates to the ISMS House appears in the convention program.

## EX-OFFICIO MEMBERS OF THE HOUSE WITHOUT THE RIGHT TO VOTE

### Past Presidents

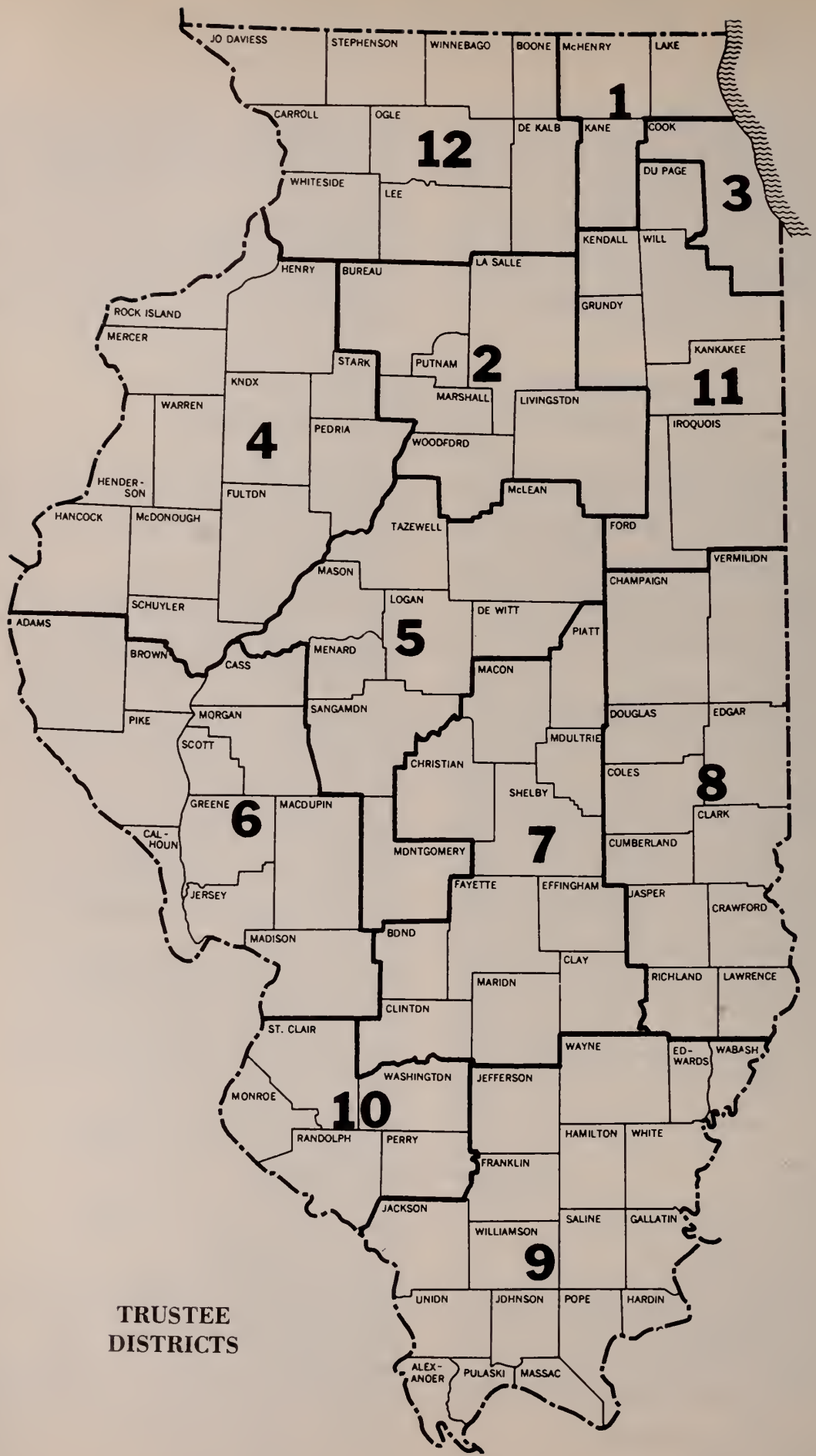
J. Ernest Breed .....1971
Everett P. Coleman .....1945-1946
Edward W. Cannady .....1970
Newton DuPuy .....1968
Harlan English .....1964
Edwin S. Hamilton .....1962
H. Close Hesseltine .....1961
J. M. Ingalls .....1976
Charles J. Jannings, III .....1972
Frank J. Jirka, Jr. .....1973
Fredric D. Lake .....1975
Willis I. Lewis .....1954
Burtis E. Montgomery .....1966
Edward A. Piszczek .....1965
Caesar Portes .....1967
Willard C. Scrivner .....1974
Joseph H. Skom .....1977
Leo P. A. Sweeney .....1953
Philip G. Thomsen .....1969
George T. Wilkins, Jr. .....1978

### Past Trustees

Earl H. Blair
Chicago, Trustee of the 3rd District
Joseph Bordenave, Geneva
Trustee of the 1st District
Walter C. Bornemeier
Chicago, Trustee of the 3rd District
Herbert Dexheimer
Belleville, Trustee of the 10th District
Alfred Faber, Northbrook
Trustee of the 3rd District
George E. Giffin
Princeton, Trustee of the 2nd District
Arthur F. Goodyear
Decatur, Trustee of the 7th District
Lee N. Hamm
Lincoln, Trustee of the 5th District
Eugene Hoban
Chicago, Trustee of the 3rd District
Ross Hutchison, Gibson City
Trustee of the 11th District
Eugene P. Johnson
Casey, Trustee of the 8th District
Ted LeBoy
Chicago, Trustee of the 3rd District
Wm. M. Lees
Lincolnwood, Trustee of the 3rd District
A. Edward Livingston
Bloomington, Trustee of the 5th District
Joseph R. O'Donnell
Glen Ellyn, Trustee of the 11th District
Mather Pfeiffenberger
Alton, Trustee of the 6th District
Ralph N. Redmond
Sterling, Trustee of the 2nd District
George Shropshear
Chicago, Trustee of the 3rd District
Darrell H. Trumpe
Springfield, Trustee of the 5th District
Frederick E. Weiss
Harvey, Trustee of the 3rd District
Charles K. Wells
Mt. Vernon, Trustee of the 9th District
Herman Wing, Chicago
Trustee of the 3rd District
Warren W. Young
Indiana, Trustee of the 3rd District
Paul P. Youngberg
Moline, Trustee of the 4th District

### Past Speakers

Walter C. Bornemeier, Chicago .....1961-1964
Andrew J. Brislen, Chicago .....1974-1975
Edward W. Cannady, Belleville .....1964-1967
Maurice M. Hoeltgen, Chicago .....1967-1970
James A. McDonald, Geneva .....1976-1977
Paul W. Sunderland, Gibson City .....1970-1973




**TRUSTEE DISTRICTS**

# TRUSTEE DISTRICT COMMITTEES

## First District

John J. Ring, Mundelein, *Trustee*
Counties of Kane, Lake, McHenry

| Ethical Relations Committee | Term Expires |
|---|---|
| David Clark, Aurora | 1981 |
| Emanuel Herzon, Elgin | 1981 |
| Gerald Liesen, St. Charles | 1979 |
| A. M. Rosetti, McHenry | 1980 |
| **Peer Review Committee** | |
| David Helberg, Waukegan, *Chairman* | 1981 |
| Eugene Pitts, Waukegan | 1981 |
| James Pritchard, Geneva | 1981 |
| Peter Vinceguerra, Libertyville | 1981 |

## Second District

Allan L. Goslin, Streator, *Trustee*
Counties of Bureau, LaSalle, Livingston, Marshall, Putnam, Woodford

| Ethical Relations Committee | Term Expires |
|---|---|
| William Erkonen, Streator, *Chairman* | 1980 |
| Julius Kowalski, Princeton | 1980 |
| Karl T. Deterding, Pontiac | 1980 |
| **Peer Review Committee** | |
| Louis Tarsinos, Princeton, *Chairman* | 1979 |
| James B. Aplington, LaSalle | 1979 |
| Francis J. Brennan, Utica | 1979 |
| Silvio Davito, Spring Valley | 1979 |
| Bernard J. Doyle, LaSalle | 1979 |
| William Ehling, Streator | 1980 |
| P. Lymberopoulis, Princeton | 1979 |
| Rowland Musick, Mendota | 1979 |
| Theodore Mauger, Chatsworth | 1981 |
| Theodore W. Wagenknecht, Streator | 1979 |

## Third District

Alfred Clementi, Arlington Heights, *Trustee*
Raymond DesRosiers, Chicago, *Trustee*
Robert T. Fox, Glenview, *Trustee*
Jere Freidheim, Chicago, *Trustee*
Morris T. Friedell, Chicago, *Trustee*
Henrietta Herbolsheimer, Chicago, *Trustee*
Lawrence L. Hirsch, Chicago, *Trustee*
Harold J. Lasky, Chicago, *Trustee*
Richard N. Rovner, Chicago, *Trustee*
Joseph C. Sherrick, Chicago, *Trustee*

## Fourth District

Fred Z. White, Chillicothe, *Trustee*
Counties of Fulton, Hancock, Henderson, Henry, Knox, McDonough, Mercer, Peoria, Rock Island, Schuyler, Stark, Warren

| Ethical Relations Committee | Term Expires |
|---|---|
| Richard Icenogle, Roseville, *Chairman* | 1980 |
| John Bowman, Abingdon | 1979 |
| George Burke, Rock Island | 1981 |
| **Peer Review Committee** | |
| Donald Dexter, Macomb, *Chairman* | 1980 |
| William Daugherty, Moline | 1981 |
| Jackson K. Erffmeyer, Galesburg | 1979 |
| G. W. Giebelhausen, Peoria | 1981 |
| James C. Parsons, Geneseo | 1979 |
| Clarence Ward, Peoria | 1981 |

## Fifth District

Paul F. Mahon, Springfield, *Trustee*
Counties of DeWitt, Logan, McLean, Mason, Menard, Montgomery, Sangamon, Tazewell

| Ethical Relations Committee | Term Expires |
|---|---|
| Richard H. Suhs, Springfield, *Chairman* | 1980 |
| Jack Means, Mason City | 1981 |
| A. L. Van Ness, Bloomington | 1979 |
| **Peer Review Committee** | |
| James Borgerson, Mt. Pulaski, *Chairman* | 1980 |
| Robert Price, Bloomington, *Co-Chairman* | 1980 |
| George Irwin, Bloomington | 1979 |
| Paul Lafata, Springfield | 1980 |
| Alton J. Morris, Springfield | 1979 |
| Robert B. Perry, Lincoln | 1979 |
| James Weimer, Pekin | 1979 |

## Sixth District

Robert R. Hartman, Jacksonville, *Trustee*
Counties of Adams, Brown, Calhoun, Cass, Green, Jersey, Macoupin, Madison, Morgan, Pike, Scott

| Ethical Relations Committee | Term Expires |
|---|---|
| Newton DuPuy, Quincy, *Chairman* | 1980 |
| Bernard Baalman, Hardin | 1981 |
| Edward K. DuVivier, Alton | 1980 |
| Joseph J. Grandone, Gillespie | 1980 |
| C. B. Lara, Pittsfield | 1981 |
| Robert Roy, Jacksonville | 1981 |
| **Peer Review Committee** | |
| Walter Stevenson III, Quincy, *Chairman* | 1980 |
| E. C. Bone, Jacksonville | 1979 |
| Robert England, Carlinville | 1981 |
| Robert C. Murphy, Quincy | 1979 |
| B. Frank Norbury, Jacksonville | 1981 |
| Edward Ragsdale, Alton | 1980 |
| James Sutherland, Quincy | 1980 |

## Seventh District

Alfred J. Kiessel, Decatur, *Trustee*
Counties of Bond, Christian, Clay, Clinton, Effingham, Fayette, Macon, Marion, Moultrie, Piatt, Shelby

| Ethical Relations Committee | Term Expires |
|---|---|
| C. R. Daisy, Greenville, *Chairman* | 1981 |
| D. M. Rames, Vandalia | 1979 |
| Charles Stanley, Decatur | 1979 |

Peer Review Committee

| | |
|---|---|
| Stanley Moore, Vandalia, *Chairman* | 1979 |
| M. K. Kaufman, Greenville | 1980 |
| H. Gale Zacheis, Decatur | 1980 |
| Walter P. Plassman, Centralia | 1979 |

## Eighth District

James Laidlaw, Champaign, *Trustee*
Counties of Champaign, Clark, Coles, Crawford, Cumberland, Douglas, Edgar, Jasper, Lawrence, Richland, Vermilion

| Ethical Relations Committee | Term Expires |
|---|---|
| Mack W. Hollowell, Charleston, *Chairman* | 1980 |
| James H. Pass, Olney | 1981 |
| Michael Murray, Olney | 1979 |

Peer Review Committee

| | |
|---|---|
| Michael Murray, Olney, *Chairman* | 1979 |
| E. T. Baumgart, Danville | 1980 |
| George T. Michell, Marshall | 1981 |
| George Perlstein, Champaign | 1979 |
| C. E. Ramsey, Charleston | 1979 |
| Gordon Sprague, Paris | 1979 |

## Ninth District

Warren D. Tuttle, Harrisburg, *Trustee*
Counties of Alexander, Edwards, Franklin, Gallatin, Hamilton, Hardin, Jackson, Jefferson, Johnson, Massac, Pope, Pulaski, Saline, Union, Wabash, Wayne, White, Williamson.

| Ethical Relations Committee | Term Expires |
|---|---|
| Alex Goldstein, Harrisburg, *Chairman* | 1979 |
| Eli Borkon, Carbondale | 1980 |
| Robert Rader, Anna | 1980 |

Peer Review Committee

| | |
|---|---|
| C. J. Jannings, III, Fairfield, *Chairman* | 1979 |
| Philip D. Boren, Carmi | 1980 |
| Herbert V. Fine, Carterville | 1981 |
| James Heersma, Mt. Vernon | 1979 |
| Harry L. Lewis, Benton | 1981 |
| Charles K. Wells, Mt. Vernon | 1979 |

## Tenth District

Julian W. Buser, Belleville, *Trustee*
Counties of Monroe, Perry, Randolph, St. Clair, Washington

| Ethical Relations Committee | Term Expires |
|---|---|
| H. P. Dexheimer, Belleville, *Chairman* | 1979 |
| Roy Kenney, E. St. Louis | 1979 |
| Edilberto Maglasang, Columbia | 1979 |
| Wm. A. Simmons, Belleville | 1979 |

Peer Review Committee

| | |
|---|---|
| William H. Walton, Belleville, *Chairman* | 1981 |
| Benjamin Arenas, Belleville | 1979 |
| Ted Bryan, Belleville | 1979 |
| R. W. Jost, Waterloo | 1981 |
| R. E. Schettler, Red Bud | 1980 |
| Ron Welch, Belleville | 1981 |

## Eleventh District

Kenneth Hurst, Naperville, *Trustee*
Counties of DuPage, Ford, Grundy, Iroquois, Kankakee, Kendall, Will

| Ethical Relations Committee | Term Expires |
|---|---|
| James Ryan, Kankakee, *Chairman* | 1981 |
| Lawrence D. Lee, Manhattan | 1979 |
| Merle Otto, Frankfurt | 1979 |
| William C. Perkins, West Chicago | 1979 |

Peer Review Committee

| | |
|---|---|
| James Campbell, Wheaton, *Chairman* | 1981 |
| James E. Dailey, Watseka | 1981 |
| James Lambert, Joliet | 1979 |
| Guy Pandola, Joliet | 1981 |
| A. G. Parkhurst, Kankakee | 1980 |
| W. H. Brill, Oswego | 1980 |
| Charles G. White, Naperville | 1979 |

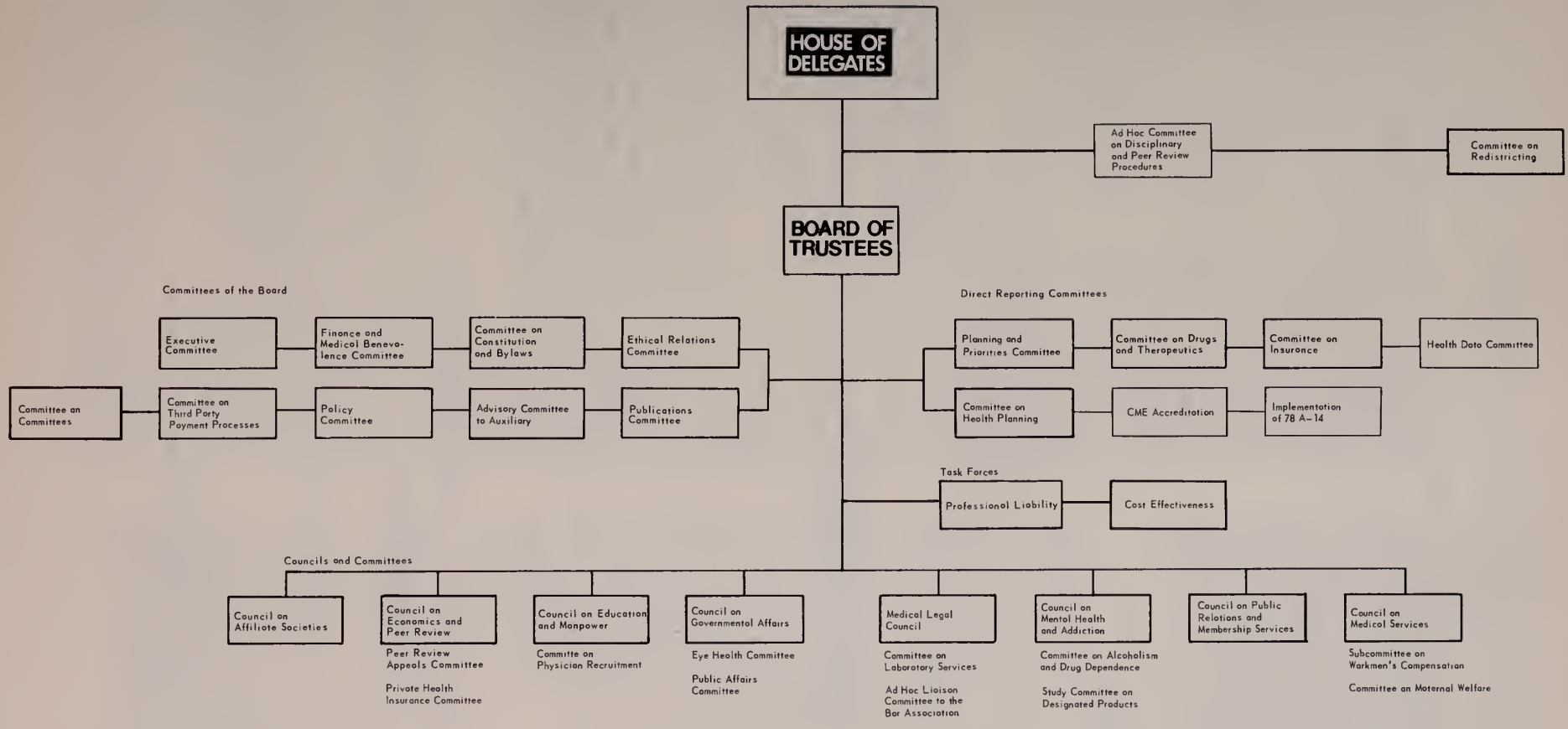
## Twelfth District

Joseph Perez, Rockford, *Trustee*
Counties of Boone, Carroll, DeKalb, Jo Daviess, Lee, Ogle, Stephenson, Whiteside, Winnebago

| Ethical Relations Committee | Term Expires |
|---|---|
| John H. Steinkamp, Belvidere, *Chairman* | 1981 |
| Keith Wrage, Rockford | 1980 |
| Frank Luedke, DeKalb | 1981 |
| John L. Clark, Freeport | 1979 |

Peer Review Committee

| | |
|---|---|
| Keith Wrage, Rockford, *Chairman* | 1980 |
| Frank Luedke, DeKalb | 1981 |
| John L. Clark, Freeport | 1979 |
| John H. Steinkamp, Belvidere | 1981 |




Organizations Directly Related to ISMS

- Illinois Foundation for Medical Care
- Illinois Council on Continuing Medical Education
- Illinois State Medical Benevolent Fund., Inc.
- Illinois State Medical Insurance Services, Inc.
- Illinois State Medical Inter-Insurance Exchange
- ISMS Educational and Scientific Foundation
- Student Loan Fund Board
- Student Business Session
- Resident Physician Section

Organizations with formal ISMS Representation

- Swanberg Foundation
- Ill. Society, American Association of Medical Assistants
- Ill. Council of Home Health Agencies
- Chicago Alliance for VD Awareness
- Pediatric Coordinating Council
- Ill. Interagency Council on Smoking and Disease
- M.D. Committee on Optometry
- The Commission on Children
- INA/ISMS Joint Practice Comm.
- Ill. Medical Records Assn.
- Illinois Cancer Council
- Illinois Cooperative Health Data Systems
- Citizen's Committee for an Illinois Program to Control High Blood Pressure
- U.S. Pharmacopoeia

# Councils of the Illinois State Medical Society

Councils of the Illinois State Medical Society are appointed by the Chairman of the Board of Trustees subject to approval of the Board of Trustees. The councils are composed of such members as are necessary to accomplish the purposes of the council. Some committees are composed of members of the Board of Trustees and are designated Board Committees. Some free standing committees may report directly to the board and may not be assigned to a council. Task Forces are established to address a particular problem or concern which crosses areas of responsibility of the several councils. The task forces report directly to the board, as do representatives to various other agencies. The President, President-Elect, Speaker of the House, and Chairman of the Board are, by virtue of their office, ex-officio members of all groups.

## COUNCIL ON AFFILIATE SOCIETIES

Norman M. Frank, Clarendon Hills, *Chairman*
Ill. Chap., Amer. Academy of Family Phy.
Ronald Albrecht, Chicago
Ill. Society of Anesthesiologists
Robert Anzinger, Chicago
Ill. Chap., Amer. Coll. of Emergency Physicians
Robert Betasso, Ottawa
Ill. Chap., Amer. Coll. of Surgeons
Jack Clemis, Chicago
Chicago Laryngological & Otological Society
John Coleman, Chicago
Ill. Society of Internal Medicine
Richard Dukes, Urbana
Ill. Chap., American Academy of Pediatrics
Carl Garfinkle, Arlington Heights
Ill. Association of Ophthalmology
Jack L. Gibbs, Canton
Ill. Surgical Society
Patrick Guinan, Chicago
Chicago Urological Society
John P. Harrod Jr., Chicago
Ill. Section, Amer. College of OB-GYN
B. Jay Hill, Chicago
Ill. Radiological Society
Gerald G. Hoffman, Lake Forest
Ill. Society of Pathology
Martin J. Kaplan, Highland Park
The Allergy & Clinical Immunology Soc. of Ill.
M. Barry Kirschenbaum, Chicago
Ill. Dermatological Society
Robert J. Kramer, Joliet
Ill. Soc. of Ophthalmology & Otolaryngology
James F. Kurtz, LaGrange
Ill. Orthopaedic Soc.
Armand Littman, Hines
Ill. Chap., Amer. College of Physicians
Ronald P. Pawl, Chicago
Ill. Neurosurgical Society
J. Roger Powell, Urbana
Ill. OB-GYN Society
David Rothstein, Chicago
Ill. Psychiatric Society

CONSULTANT:
Harold Lasky, Chicago
Cyril Wiggishoff, Chicago

STAFF: Division for Specialty Societies

**Responsibilities and Purposes:**
To improve communication and provide liaison with the specialty societies; provide specialty consultation to other ISMS councils and committees; and to serve as a resource unit to ISMS on advances in the medical specialties.

## COUNCIL ON ECONOMICS AND PEER REVIEW

Michael E. Murray, Olney, *Chairman*
William A. Hutchison, Chicago
Robert E. Knight, Normal
Herbert E. Natof, Highland Park
Roger N. Pesch, Wheaton
Robert Prentice, Springfield
James J. Rybak, Lincolnshire
John S. Schweppe, Chicago
Frank C. Sedlak, Riverside
Alex Spadoni, Joliet
Fred A. Tworoger, Chicago
Ronald G. Welch, Belleville
Ben Williams, Urbana

CONSULTANTS
Allan L. Goslin, Streator
Henrietta Herbolsheimer, Chicago
Joseph Perez, Rockford

RESIDENT
James DeBord, Oak Park

STUDENT
Debbie Frei-Lahr, Chicago

STAFF: Division of Medical Services

**Responsibilities and Purposes:**
The Council on Economics & Peer Review shall concern itself with: 1) relations with the health insurance industry and prepayment plans; 2) fees and fee adjudication as promulgated by the ISMS; 3) health care cost and utilization; 4) new modes of health care delivery (prepaid programs, surgicenters, etc., peer review and quality of care).

**Committees:**
Peer Review Appeals
Private Health Insurance

## PEER REVIEW APPEALS COMMITTEE

Ben Williams, Urbana, *Chairman*
Robert E. Knight, Normal
Robert Prentice, Springfield
John S. Schweppe, Chicago
Frank C. Sedlak, Riverside
Ronald G. Welch, Belleville
Debbie Frei-Lahr, Chicago
STAFF: Division of Medical Services

**Responsibilities and Purposes:**

The Peer Review Appeals Committee serves as the appellate body for peer review in the state. It considers cases being appealed from local or district Peer Review committees involving quality and cost of medical care. The committee also serves as liaison to local peer review committees.

## PRIVATE HEALTH INSURANCE COMMITTEE

Herbert E. Natof, Highland Park, *Chairman*
William A. Hutchison, Chicago
Roger N. Pesch, Wheaton
James J. Rybak, Lincolnshire
Alex Spadoni, Joliet
Fred A. Tworoger, Chicago
James DeBord, Oak Park
STAFF: Division of Medical Services

**Responsibilities and Purposes:**
To conduct ongoing relationships with the private health insurance industry and to deal with issues involving medical policies, reimbursement and complaints.

## COUNCIL ON EDUCATION AND MANPOWER

Charles T. McHugh, Chicago, *Chairman*
Murray Brown, Chicago
Milda Budrys, Chicago
Allison Burdick, Jr., Chicago
John Devitt, Springfield
William M. Lees, Hines
Eugene T. Leonard, Rockford
Joseph P. McKay, Elmhurst
Pedro Poma, Chicago
David Roxe, Chicago
Allen L. Wright, Chicago
Simon Zivin, Chicago

STUDENT
John P. Johnson (Loyola), Forest Park

CONSULTANTS
Lawrence Hirsch, Chicago
Fred Z. White, Chillicothe

STAFF: Division of Education, Manpower and Convention Services

**Responsibilities and Purposes:**

The Council on Education and Manpower shall study and evaluate all phases of medical education, including the development of programs by and for ISMS, and review programs for paramedical personnel. It shall carry to the deans of medical schools recommendations from the viewpoint of the practicing physician. It shall evaluate available postgraduate programs, advise the Illinois Dept. of R&E, and review hospital oriented education programs. Liaison shall be maintained with medical students and physicians-in-training and with loan programs for medical students. Activities regarding physician distribution and retention shall also be within the scope of the Council, as well as medical licensure as it relates to education.

**Committee:**

Physician Recruitment

---

## GOVERNMENTAL AFFAIRS COUNCIL

Tassos Nassos, Chicago, *Chairman*
Howard Burkhead, Evanston
James Cavanaugh, Jr., Winnetka
David Christy, Watseka
David Clark, Aurora
Robert England, Carlinville
Edwin Falloon, Evergreen Park
Edward G. Ference, Springfield
William D. Fish, Chicago
Delbert Hahn, Decatur
Don Hinderliter, Rochelle
Frank J. Kresca, Champaign
Michael Victor, Buffalo Grove
Walter Whisler, Chicago

ILL. CLINIC MGRS. ASSOC. REP.
Norma de la Cerna, Chicago

AUXILIARY REPRESENTATIVE
Mrs. Byron Weisbaum, Springfield

RESIDENT PHYSICIANS REPRESENTATIVE
Linda Hughey, Chicago

STUDENT REPRESENTATIVE
Michael I. Kulick, Chicago

CONSULTANTS
Robert T. Fox, Glenview
James Laidlaw, Champaign

STAFF: Governmental Affairs Division

**Responsibilities and Purposes:**

1. Keep the Society and its members aware of all state and federal legislation and laws affecting the health of citizens of Illinois and the practice of medicine in Illinois.
2. Promulgate legislation to improve the health care of citizens of Illinois and the practice of medicine in Illinois.
3. Co-operate with the AMA in similar programs.
4. Develop programs to educate the public and the Illinois State Medical Society membership in the privileges and responsibilities of citizenship.

**Committees:**

Ad Hoc Eye Health
Public Affairs

## AD HOC EYE HEALTH COMMITTEE

Frank J. Kresca, Champaign, *Chairman*
Charles Mullenix, Glenview
Burton Russman, Chicago
Frank Snell, Decatur
Robert W. Webb, East Alton

## PUBLIC AFFAIRS COMMITTEE

Don Hinderliter, Rochelle, *Chairman*
James H. Andersen, Oak Brook
Theodore Grevas, Rock Island
Michael P. Phillips, Chicago
Edward Ragsdale, Godfrey
Albert W. Ray, Jr., Joliet
Ronald E. Sumner, Peoria

AUXILIARY REPRESENTATIVE
Mrs. David Clark, Aurora

STAFF: Division of Field Services

**Responsibilities and Purposes:**

The Public Affairs Committee is responsible for educating physicians about the political process and encouraging political involvement. The Committee also provides educational material on issues of interest to physicians and promotes physician involvement in public affairs activity.

## MEDICAL LEGAL COUNCIL

Eugene Vickery, Lena, *Chairman*
Donald Aaronson, Chicago
Nelson Borelli, Wilmette
Leonard Klafta, Joliet
Guy Matthew, Glen Ellyn
Morgan Meyer, Lombard
Michael Murphy, Belleville
Lawrence K. Richards, Urbana
Marshall Segal, Chicago
Sam Sugar, Evanston
J. Robert Thompson, Chicago *(Lab. Services)*
Charles Wells, Mt. Vernon

CONSULTANT
Alfred Kiessel, Decatur

STUDENT REPRESENTATIVE
Joseph Fallon, Oak Park

STAFF: Division of Publications, Medical-Legal and Mental Health

**Responsibilities and Purposes:**

The Medical Legal Council shall cooperate with all organizations interested in medico-legal problems in order to educate members of the profession in medico-legal affairs.

This council shall maintain liaison with the Illinois Bar Association and cooperate with the judiciary in both federal and state courts within the state of Illinois. It shall, when requested by the court, activate the Impartial Medical Testimony panel. The stated objective of the panel is to provide consultations, judgment and opinions in situations in which there is unusual controversy or wide divergence of medical opinion.

The council shall study recommendations for methods of elevating and maintaining the standards of medical laboratories in Illinois. In addition, the council shall be concerned with standards of practice, licensure and quackery.

**Committees:**

Impartial Medical Testimony
Laboratory Services

## COMMITTEE ON LABORATORY SERVICES

J. Robert Thompson, Oak Park, *Chairman*
Robert Carrara, Geneva
Joseph O. Dean, Peoria
Newell Braatelein, Moline

STAFF: Division of Publications, Medical-Legal and Mental Health

**Responsibilities and Purposes:**

The committee shall monitor methods of elevating and maintaining the standards of medical laboratories in Illinois, encourage the use of medical diagnostic laboratories supervised by duly qualified physicians and encourage each county and district to establish evaluation committees. It will cooperate with various state agencies in promoting a safe, adequate blood supply for the state.

---

## COUNCIL ON MENTAL HEALTH AND ADDICTION

Arthur R. Traugott, Urbana, *Chairman*
Douglas R. Bey, Normal
Anthony Busch, Belleville
Warren R. Dammers, Harrisburg
Marvin Dehaan, Wayne
Thomas E. Kirts, DeKalb
Geoffrey L. Levy, Arlington Heights
Edward Senay, Chicago *(IPS Liaison)*
Ronald Shlensky, Chicago
Patrick Staunton, Oak Park
James West, Evergreen Park
*(Comm. on Alcoholism & Drug Dependence)*
Arthur Woloshin, Highland Park

CONSULTANTS
George T. Wilkins, Granite City
Cyril C. Wiggishoff, Chicago

RESIDENT REPRESENTATIVE
Jesse Viner, Chicago

STUDENT REPRESENTATIVE
Brad Epstein, Chicago

STAFF: Division of Publications, Medical-Legal and Mental Health

**Responsibilities and Purposes:**

This council shall serve as a source of information on mental health matters for ISMS, evaluate information and make recommendations to the Board of Trustees on positions ISMS should take on issues in this area, and cooperate with institutions, voluntary health agencies, state agencies and professional associations in disseminating information on mental health, alcoholism and drug abuse.

The council shall be on the alert for misleading or fallacious programs and information and recommend appropriate action. It shall also be concerned with reviewing legislation and regulations related to the field of mental health, alcoholism, drug abuse, and hazardous substances.

**Committee:**

Alcoholism and Drug Dependence

## COMMITTEE ON ALCOHOLISM AND DRUG DEPENDENCE

James West, Evergreen Park, *Chairman*
Lee Gladstone, Chicago
Kermit Mehlinger, Chicago
Reinhold Schuller, Bourbonais
Edward Senay, Chicago
George Stanton, Chicago
W. David Steed, Oak Park
David Stinson, Rockford

CONSULTANTS
Linda Hargnett, DDC, Chicago
Msgr. Ignatius McDermott, Chicago Catholic Charities
J. Roalda Alderman, Div. of Alcoholism, Chicago
Mrs. Harold Keegan, ISMS Auxiliary, Kankakee

STAFF: Division of Publications, Medical-Legal and Mental Health

**Responsibilities and Purposes:**

The Committee shall work closely with public and private agencies on projects aimed at eliminating the misuse of alcohol and drugs. The committee's functions include: (1) study, research and disseminate educational information on drugs and alcohol to members of the medical profession; (2) cooperate in the dissemination of information on the causes, prevention, diagnosis and treatment of alcoholism and drug dependence to the medical profession and to the public; (3) recommend acceptable measures for control of distribution and disposal of drugs and hazardous substances, exclusive of radiation products, and (4) cooperate with official and non-official agencies in all matters pertaining to this subject.

In April, 1977, ISMS established the Panel for the Impaired Physician. The Panel, which reports to the Committee on Alcoholism and Drug Dependence, consists of physicians who treat fellow physicians for problems related to alcohol or drug dependence, as well as impairment due to mental or emotional disturbances. Referrals to the Panel are initiated through the chairman of the Committee on Alcoholism and Drug Dependence.

## COUNCIL ON PUBLIC RELATIONS AND MEMBERSHIP SERVICES

Mack W. Hollowell, Charleston, *Chairman*
James R. Adams, Winnetka
Robert Boxer, Skokie
Robert Hamilton, Chicago
Richard A. Perritt, Chicago
David Spindel, Chicago
Peter Vinciguerra, Libertyville

CONSULTANT:
Jere Freidheim, Chicago

RESIDENT:
Ira Isaacson, Chicago

STUDENT MEMBER:
Jerrold B. Leikin, Skokie

AUXILIARY REPRESENTATIVE
Mrs. Harlan Failor, Champaign

STAFF: Division of Public Relations and Membership Services

**Responsibilities and Purposes:**

The Council on Public Relations and Membership Services shall plan and execute programs designed to enhance the relationship between the media, clergy, general public and medical profession. Included shall be health education and socio-economic programs believed to be in the best interest of the profession as well as the general public. The council shall be responsible for new member orientation, exhibits and public service programming.

## COUNCIL ON MEDICAL SERVICES

Glen Tomlinson, Lincoln, *Chairman*
Helen C. Bonbrest, Chicago
Joan Cummings, Hines
William W. Curtis, Springfield
Thomas H. Davison, Chicago
Herbert B. Fine, Carterville
Lee Johnson, Litchfield
A. Everett Joslyn, River Forest
Garland P. Kirkpatrick, Chicago
Max Klinghoffer, Elmhurst
David B. Littman, Highland Park
Shirley A. Roy, Chicago
Edward Ryan, Palos Heights
Joseph D. Winterhalter, Rockford

CONSULTANTS:
Alfred Clementi, Arlington Heights
Kenneth A. Hurst, Naperville
Paul Q. Peterson, M.D., Director, IDPH, Springfield
John J. Ring, Mundelein

AUXILIARY REPRESENTATIVE
Mrs. James Gwaltney, Quincy

STUDENT REPRESENTATIVE
Mark DuPuis, Westchester

STAFF: Division of Medical Services

**Responsibilities and Purposes:**

The Council initiates and implements programs related to health education, medical facilities and services. It also maintains liaison with other health care organizations involved with vocational rehabilitation, Workmen's Compensation, aging, the poor, rural areas and emergency medical services.

In addition, the Council and its Committee on Maternal Welfare cooperate with the Illinois Department of Public Health in the maintenance, protection and improvement of the health of the people of Illinois.

**Committees:**
Maternal Welfare
Committee on Workmen's Compensation
Ad Hoc Committee on the Generic Prescribing Law

## COMMITTEE ON MATERNAL WELFARE

DISTRICTS MEMBERS AND ALTERNATES
*(alternates in italics)*
William W. Curtis, Springfield, *Chairman*
1. Hugh C. Falls, Lake Forest
*Gan L. Tjiook,* Geneva
2. William J. Farley, Peru
*Carl P. Mattioda,* Streator
3. Alex Kaz, Harvey
*Charles F. Kramer,* Glenwood
4. Ralph Gibson, Peoria
*Raoul E. Reinertsen,* Canton
5. William W. Curtis, Springfield
*Robert Maletich,* Springfield
6. Richard D. Yoder, Alton
*Donald E. Hardbeck,* Alton
7. Herbert W. Thompson, Decatur
8. J. Roger Powell, Urbana
*John C. Mason, Jr.,* Danville
9. William B. Skaggs, Harrisburg
*Urduja Pulido,* Murphysboro
10. Arthur A. Smith, O'Fallon
*Ferdinand J. Mueller,* Belleville
11. John J. McLaughlin, Joliet
*Charles P. Westfall,* Elmhurst
12. John F. Hubbard, Sterling
*Gordon T. Burns,* Rockford

CONSULTANTS:
Robert R. Hartman, Jacksonville
John Louis, Lake Forest
Augusta Webster, Chicago

STAFF: Division of Medical Services

## COMMITTEE ON WORKMEN'S COMPENSATION

Thomas Davison, Chicago, *Chairman*
Ernest F. Adams, Peoria
Harry C. Coblens, Chicago
Eugene J. Rogers, Chicago
Vincent Sarley, North Chicago
Joseph Schiff, Chicago

STAFF: Division of Medical Services

**Responsibilities and Purposes:**

To review how physicians are involved and affected by the Workmen's Compensation system in Illinois.

## AD HOC COMMITTEE ON THE GENERIC PRESCRIBING LAW

Vincent A. Costanzo, Chicago, *Chairman*
Raymond Dieter, Glen Ellyn
Robert P. Johnson, Springfield
Michael Murphy, Belleville
Richard H. Suhs, Springfield

STAFF: Division of Medical Services

**Responsibilities and Purposes:**

This Committee is responsible for monitoring the implementation of the Generic Prescribing Law.

## STATE TECHNICAL ADVISORY COMMITTEE ILLINOIS JAIL HEALTH PROGRAM, 1978-1979

Robert J. Kramer, Joliet, *Chairman*
Margaret Connolly, Illinois Nurses Association
Robert Davison, Illinois State Bar Association
Lee Johnson, Litchfield
Courtney Jones, Chicago
Barbara Lewis, Association of Administration of Ambulatory Services
Cecil Patmon, Illinois Department of Corrections
Mary Lou Pflum, Division of Ambulatory Care, IDPH
Tony Slas, Illinois Pharmaceutical Association
Arthur Tyrrell, Illinois Sheriffs' Association
Joseph D. Winterhalter, Jacksonville

STAFF: Division of Medical Services

**Responsibilities and Purposes:**

To provide overall direction to the Illinois Jail Health Program and assist jails in adapting their health systems to meet national standards for medical care delivery. The STAC Committee is an independent body which reports to the Council on Medical Services.

# Committees of the Board of Trustees

## COMMITTEE ON CONSTITUTION AND BYLAWS

James Laidlaw, Champaign, *Chairman*
Robert T. Fox, Glenview
Henrietta Herbolsheimer, Chicago
John J. Ring, Mundelein
Cyril C. Wiggishoff, Chicago

CONSULTANT: Legal Counsel

STAFF: Division of Education, Manpower and Convention Services

**Responsibilities and Purposes:**

The Committee on Constitution & Bylaws shall:
1) Receive from individual members, county societies, committees, the Board of Trustees and the House of Delegates, all suggestions and proposals for modification of the Constitution & Bylaws;
2) Prepare for the consideration of the House of Delegates, all changes in the Constitution & Bylaws; and
3) Maintain constant surveillance of both documents to keep them current, effective and consistent with the policies of the House of Delegates.

## ETHICAL RELATIONS COMMITTEE

Jere E. Freidheim, Chicago, *Chairman*
Julian W. Buser, Belleville
Morris T. Friedell, Chicago
G. W. Giebelhausen, Peoria
Paul F. Mahon, Springfield
Joseph Perez, Rockford

STAFF: Division of Medical Services

**Responsibilities and Purposes:**

The responsibilities and purposes of this committee are outlined in CHAPTER XI. DISCIPLINE, Part 2 *Illinois State Medical Society Procedures.*

## EXECUTIVE COMMITTEE

Robert R. Hartman, Jacksonville, *Chairman*
David S. Fox, Chicago
P. John Seward, Rockford
Herschel Browns, Chicago
Allan Goslin, Streator
Audley Connor, Chicago
George T. Wilkins, Edwardsville
Robert T. Fox, Glenview

EX-OFFICIO (without vote):
Jack L. Gibbs, Canton

BY INVITATION (without vote)
Cyril C. Wiggishoff, Chicago

STAFF: Division of Administration

**Responsibilities and Purposes:**

The Executive Committee shall consist of the president, the president-elect, the first vice president, the chairman of the Board, the chairman of the Finance and Medical Benevolence Committee, the secretary-treasurer and the trustee-at-large. The immediate past chairman of the Board shall be a member, provided he is still a Trustee. If the immediate past chairman is no longer a Trustee, the chairman of the Policy Committee shall serve on the Executive Committee.

The chairman of the Illinois Delegation to the American Medical Association, or the secretary in his absence, shall serve as an ex-officio member of the Executive Committee without vote.

It may be given authority to act by the Board of Trustees.

In matters of routine administration, special plans, policy, endorsement or expenditure it shall report to and request approval of the Board. It shall receive the reports of the Finance and Policy Committees and make recommendations concerning them to the Board. It shall furnish a report of its actions to the Board at each meeting.

(Bylaws, Chapter IX, Part 4, Section 2, Paragraph A.)

## FINANCE COMMITTEE AND MEDICAL BENEVOLENCE

Allan L. Goslin, Streator, *Chairman*
Alfred Clementi, Arlington Heights
Audley F. Connor, Sr., Chicago
Warren D. Tuttle, Harrisburg

STAFF: Division of Administration

**Responsibilities and Purposes:**

The Committee shall consist of the secretary-treasurer of the Society and three members of the Board appointed by the chairman. It shall develop a budget for the fiscal year for approval of the Board through the Executive Committee. It shall supervise the financial transactions of the Society. It shall make recommendations to the Board for the control and investment of the funds of the Illinois State Medical Society.

The Finance Committee shall also be responsible for the society's Medical Benevolence Program and shall:

1. Examine applications for financial assistance and determine eligibility.

2. Keep the names of the beneficiaries confidential and known only to the committee.

3. Determine the allotment for each recipient.

4. If funds available become inadequate to meet disbursements, request the Board of Trustees to appropriate sufficient funds to support the program until the next budget appropriation.

## THIRD PARTY PAYMENT PROCESSES COMMITTEE

P. John Seward, Rockford, *Chairman*
Raymond DesRosiers, Chicago
Allan L. Goslin, Streator
Richard N. Rovner, Chicago
Joseph Sherrick, Chicago
Fred Z. White, Chillicothe

Ill. Clinic Mgrs. Assoc. Rep.
Mr. Sherwin Sern, McHenry

Staff: Division of Field Services

**Responsibilities and Purposes:**

The Third Party Payment Processes Committee is responsible for matters concerning the Illinois Department of Public Aid. The Committee deals wih Medicaid reimbursement, administration, and auditing practices. The Committee also oversees the Medicaid Membership Services program.

## POLICY COMMITTEE

Lawrence L. Hirsch, Chicago, *Chairman*
Alfred J. Kiessel, Decatur
Joseph C. Sherrick, Chicago

Staff: Division of Education, Manpower and Convention Services

**Responsibilities and Purposes:**

The Policy Committee shall consist of three members of the Board appointed by the chairman. It shall continually review past and current proceedings of the House of Delegates to determine the established policies of the Illinois State Medical Society. It shall make recommendations for future policy by Board resolution to the House of Delegates.

## PUBLICATIONS COMMITTEE

Herschel Browns, Chicago, *Chairman*
Alfred Kiessel, Decatur
Robert P. Johnson, Springfield
Kenneth A. Hurst, Naperville
Harold J. Lasky, Chicago

Consultant:
Lawrence L. Hirsch, Chicago

Staff: Division of Publications, Medical-Legal and Mental Health

**Responsibilities and Purposes:**

The Publications Committee shall be composed of five members of the Board of Trustees, and shall be responsible for the production of the *Illinois Medical Journal* and other Society publications.

It shall recommend to the Board of Trustees all policies governing the editorial, business and production aspects of the *Journal*. It shall supervise the editorial board in the selection and preparation of all copy, and it shall establish standards for the editorial content.

It shall establish advertising policies, rates and standards, and shall review all new accounts prior to acceptance, and shall approve reprint and circulation policies.

It shall conduct a periodic review of the printer's contract and solicit bids as indicated. It shall establish the format, cover, type faces and general layout of the *Journal*.

The committee may establish such editorial consultation groups as necessary to assist in development of clinical articles and shall authorize all regular and special features.

**_IMJ_ Editorial Board**

J. William Roddick, Jr., Springfield, *Chairman*
Eli L. Borkon, Carbondale
Daniel R. Cunningham, Wilmette
Raymond A. Dieter, Jr., Glen Ellyn
James G. Ekeberg, Palatine
Ediz Z. Ezdinli, Kenilworth
Carl Neuhoff, Peoria
Constantine S. Soter, Northbrook
Donald D. VanFossan, Springfield

## COMMITTEE ON COMMITTEES

Henrietta Herbolsheimer, Chicago, *Chairman*
Julian Buser, Belleville
Lawrence L. Hirsch, Chicago
Paul F. Mahon, Springfield

Staff: Division of Education, Manpower and Convention Services

**Responsibilities and Purposes:**

The Committee on Committees shall consist of three members of the Board appointed by the chairman. It shall serve to review the purposes, activities and structure of any councils or committees at the request of the Board.

The committee shall recommend such changes in existing councils or committees as required to maintain the efficient operation of the affairs of the Society.

The activities and reports of the Committee on Committees shall be reviewed by the Executive Committee and approved by the Board of Trustees.

## ADVISORY COMMITTEE TO ISMS AUXILIARY

George T. Wilkins, Jr., Edwardsville, *Chairman*

David S. Fox, Chicago

Robert R. Hartman, Jacksonville

Staff: Division of Administration

**Responsibilities and Purposes:**

The committee shall consist of the immediate past president as chairman, the president, and the chairman of the Board. The committee shall provide advice and assistance to the president of the ISMS Auxiliary in her program for the year, and shall assist her in interpreting the activities of the state medical society to the auxiliary members.

# Direct Reporting Committees

All Board Committees previously noted consist of members of the Board of Trustees. As such they function within the activities of the Board.

Direct Reporting Committees are groups deemed necessary by the Board of Trustees and are created by the Board to meet specific challenges. These committees may function with, and under, a council, or may report directly to the Board of Trustees.

While other select committees may be formed from time to time, at the time of publication the following groups had been established.

## COMMITTEE ON HEALTH PLANNING

B. Smith Hopkins, Urbana, *Chairman*
Robert A. Clark, Chicago
Robert D. Dooley, Oak Brook
Alexander Z. Goldstein, Harrisburg
Charles J. Jannings, III, Fairfield
M. Kenneth Kaufmann, Greenville
C. B. Lara, Pittsfield
Anthony Raimondi, Chicago

CONSULTANTS:
Henrietta Herbolsheimer, Chicago
Alfred J. Kiessel, Decatur
Fred Z. White, Chillicothe

STAFF: Division of Field Services

**Responsibilities and Purposes:**

The Committee has responsibility for keeping physicians abreast of all developments in the area of health planning and encouraging a leadership role for physicians in this important field. The Committee maintains ongoing liaison with the State Planning Agency, the Statewide Health Coordinating Council, the Health Facilities Planning Board and the local areawide health planning agencies.

## COMMITTEE ON DRUGS AND THERAPEUTICS

Vincent A. Costanzo, Jr., Chicago, *Chairman*
Norman J. Ehrlich, Chicago
Arthur R. Marks, Fairfield
Richard H. Suhs, Springfield

CONSULTANTS:
Louis Gdalman, R.Ph., Oak Brook
Kerrison Juniper, Jr., Springfield

STAFF: Division of Education, Manpower and Convention Services

**Responsibilities and Purposes:**

The Committee shall meet periodically to refine the drug list contained in the Drug Manual. It shall work with the Illinois Department of Public Aid in an effort to keep the Drug Manual current and effective. When suggestions and comments from the members are submitted to the committee, it shall review them and present them to the Department of Public Aid when necessary. The committee shall also consider other drug matters affecting the policy of the medical society.

## COMMITTEE ON INSURANCE

William A. Henry, Springfield, *Chairman*
Phillip Boren, Carmi
Charles F. Eddingfield, Carthage
B. Franklin Lounsbury, Chicago
Franklin Yanez-Seijo, Chicago

CONSULTANT:
Alfred D. Clementi, Arlington Heights

STAFF: Division of Medical Services

**Responsibilities and Purposes:**

The Committee on Insurance will review society-sponsored insurance programs, which are currently the Tax Qualified Retirement Program (Keogh Plan), Retirement Investment Program, Group Disability Program, Business Overhead Expense Insurance, Group Major Medical Program, Hospital Benefit Program, and Group Life Insurance. The committee will study these plans, make suggestions for changes, additions and cancellation of policies, and investigate other insurance programs that may benefit society members.

## PLANNING AND PRIORITIES COMMITTEE

P. John Seward, Rockford, *Chairman*
Phillip Boren, Carmi
Herschel L. Browns, Chicago
Alfred Clementi, Arlington Heights
Howard Fishman, Hines
David S. Fox, Chicago
Jack L. Gibbs, Canton
Robert R. Hartman, Jacksonville
Lawrence L. Hirsch, Chicago
Eugene P. Johnson, Casey
Robert P. Johnson, Springfield
William M. Lees, Lincolnwood
Joseph B. Perez, Rockford
Albert W. Ray, Jr., Joliet
John J. Ring, Mundelein
Warren D. Tuttle, Harrisburg
Fred Z. White, Chillicothe
Cyril C. Wiggishoff, Chicago
George T. Wilkins, Edwardsville

STAFF: Division of Administration

**Responsibilities and Purposes:**

The President-Elect shall serve as the Chairman of the Committee on Planning and Priorities. This Committee shall review the ongoing plans and programs, establish appropriate priorities and develop plans for future programs. In the discharge of its duties it should assist the President-Elect in the formation of his objectives for accomplishment during his term as President.

## TASK FORCE ON PROFESSIONAL LIABILITY

Fredric D. Lake, Evanston, *Chairman*
Illinois State Medical Society
George Andrews, Ottawa
Ill. Assoc. Osteopathic Physicians
Thomas Baffes, Park Ridge
Chgo. Surgical Society
Marshall L. Blankenship, Homewood
Ill. Dermatological Society
Edmund C. Bolton, Chicago
Ill. Chap. Am. Coll. of Emergency Phys.
Phillip D. Boren, Carmi
Illinois State Medical Society
Joseph Caminiti, Oak Brook
Ill. Hosp. Assoc.
Clinton L. Compere, Chicago
Ill. Orthopaedic Society
George G. Curl, Oak Park
Chgo. Urological Society
David L. Doud, Normal
Amer. College of Surgeons
Charles F. Downing, Decatur
Ill. Chap., Amer. College of Phys.
Ill. Society of Internal Med.
Thomas P. Driscoll, Chicago
Ill. Chap.,
Amer. Academy of Pediatric
Deane M. Farley, Riverside
Ill. OB-GYN Society
David S. Fox, Chicago
Ill. State Medical Society
Morris T. Friedell, Chicago
Ill. State Medical Society
Herb Gardner, Oak Brook
Ill. Hospital Assoc.
John P. Harrod, Jr., Chicago
Amer. Coll. OB-GYN, Ill. Sec.
Welland A. Hause, Decatur
Ill. Soc. of Pathologists
Henri Havdala, Chicago
Ill. Soc. of Anesthesiologists
Robert P. Johnson, Springfield
Ill. State Medical Society
Alfred J. Kiessel, Decatur
Ill. State Medical Society
Harold Kirk, Oak Park
Ill. Assoc. of Ophthalmology
Robert E. Knight, Normal
Ill. Soc. of Ophth. & Otolaryngology
Harold Lasky, Chicago
Chicago Radiological Society
Robert Lindley, Chicago
Chicago Medical Society
James H. Mason, Evanston
Ill. Surgical Society
Guy Matthew, Chicago
Ill. Radiological Society
Peter McKinney, Chicago
Chicago Society of Plastic Surgery
Tassos Nassos, Chicago
Ill. State Medical Society
Robert O'Leary, Oak Brook
Illinois Hospital Association
Clyde Phillips, Chicago
Cook County Phys. Assoc.
Mark M. Pomaranc, Chicago
Ill. Chap., Amer. Coll. of Phys.
Karl Richardson, Chicago
Chicago Dental Society
David Rothstein, Chicago
Ill. Psychiatric Society
Carlo Scuderi, Chicago
Ill. Orthopaedic Society
Irwin A. Smith, Northbrook
Ill. Academy of Family Phys.
Thomas Starshak, Aurora
Ill. State Dental Society
Thomas Szwed, Chicago
Ill. Assoc. Osteo. Phys. & Surgs.
Walter W. Whisler, Chicago
Ill. Neurosurgical Society
Richard S. Wilbur, Lake Forest
Ill. State Medical Society
Don Wood, Chicago
Chicago Hospital Council

CONSULTANTS:
Joel Edelman, Esq.

## TASK FORCE ON COST EFFECTIVENESS

J. M. Ingalls, M.D., Paris, *Chairman* (ISMS)
Mr. Stephen Dorn, Chicago (Chgo. Hosp. Coun.)
Mr. Martin Drebin, Evanston (Ill. Hosp. Assoc.)
David S. Fox, M.D., Chicago (ISMS)
Robert T. Fox, M.D., Glenview (ISMS)
Morris T. Friedell, M.D., Chicago (Chgo. Med. Soc.)
Mr. Peter Goschy, Oak Brook (Ill. Hosp. Assoc.)
Mr. Charles Goulet, Chicago (BC-BS)
Robert R. Hartman, M.D., Jacksonville (ISMS)
Mr. F. Regis Kenna, Addison (Ill. Hosp. Assoc.)
Mr. Robert Lindley, Chicago (Chgo. Med. Soc.)
Mr. James Mortimer, Chicago (Loop Bank Task Force on Health)
Mr. Gerald Mungerson, Chicago (Ill. Hosp. Assoc.)
Mr. Robert O'Leary, Oak Brook (Ill. Hosp. Assoc.)
Clifton L. Reeder, M.D., Park Ridge (Chgo. Med. Soc.)
Mr. Philip J. Sayles, Woodstock (Ill. Clinic Mgrs. Assoc.)
Mr. Frank Schwermin, Highland Park, (Chgo. Hosp. Coun.)
Mr. Steve L. Seiler, Lake Forest (Ill. Hosp. Assoc.)
P. John Seward, M.D., Rockford (ISMS)
Richard C. Shaw, M.D., Chicago (BC-BS)
Mr. James R. Slawny, Chicago (ISMS)
Mr. Roger N. White, Chicago (ISMS)

## AD HOC HOUSE COMMITTEE TO STUDY REVISIONS OF DISCIPLINARY AND PEER REVIEW PROCEDURES

A. Everett Joslyn, River Forest, *Chairman*
James DeBord, Oak Park
Jere E. Freidheim, Chicago
Robert R. Hartman, Jacksonville
Lawrence L. Hirsch, Chicago
A. Beaumont Johnson, Elgin
Fredric D. Lake, Evanston
Michael E. Murray, Olney
Joseph R. O'Donnell, Glen Ellyn

CONSULTANT:
Fred Z. White, Chillicothe

STAFF: Division of Medical Services

**Responsibilities and Purposes:**

This committee was formed at the 1977 annual House of Delegates meeting to study and recommend revisions in the Society's disciplinary and peer review procedures. It reports directly to the House of Delegates.

# Other Appointments and Representatives

## REPRESENTATIVES TO STUDENT LOAN FUND BOARD

Jack Gibbs, Canton, *Chairman*
Albert G. Bledig, Eldorado
Thomas Schrepfer, Havana

STAFF: Division of Education, Manpower and Convention Services

**Purpose:**

ISMS representatives on the Student Loan Fund Board are responsible to the Board of Trustees in matters related to administration of the Student Loan Program operated jointly with the Illinois Agricultural Association.

## INA-ISMS JOINT PRACTICE COMMITTEE

James E. Coeur, Carthage
Robert M. Reardon, Bloomington
Fred Z. White, Chillicothe

STAFF: Division of Education, Manpower and Convention Services

**Responsibilities and Purposes:**

The purposes and objectives of the committee shall be to: (1) improve communication between medicine and nursing to enhance joint planning and action; (2) examine roles and functions in medical and nursing practice with definition of new and altered patterns; (3) propose changes in educational patterns and relationships that would enhance the new role functioning of nurses and physicians; (4) define, identify and examine health care needs; (5) address the traditional problems which affect nurse-physician relationships in order to establish enhanced role functioning, and (6) identify and address the ensuing problems related to basic role reorganization.

## ILLINOIS COOPERATIVE HEALTH DATA SYSTEMS

Audley F. Connor, Chicago
Joel Edelman, *Legal Counsel*, ISMS
Alexander Goldstein, Harrisburg
Allan L. Goslin, Streator
Donald H. Hanscom, Hinsdale
Henrietta Herbolsheimer, Chicago
James A. McDonald, Geneva
Joseph R. O'Donnell, Glen Ellyn
Clifton L. Reeder, Park Ridge
Roger N. White, *Executive Administrator*, ISMS
Ben T. Williams, Urbana

## ISMS REPRESENTATIVES TO OTHER GROUPS

SWANBERG FOUNDATION, QUINCY
Robert R. Hartman, Jacksonville

LIAISON TO ILL. SOC. OF THE AMER. ASSOC. OF MED. ASSTS.
J. M. Ingalls, M.D., Paris

ILLINOIS COUNCIL OF HOME HEALTH AGENCIES
Shirley A. Roy, Chicago

CHICAGO ALLIANCE FOR VD AWARENESS
Mark DuPuis, Westchester

PEDIATRIC COORDINATING COUNCIL
Daniel Pachman, Chicago

ILL. INTERAGENCY COUN. ON SMOKING AND DISEASE
Charles L. Swarts, Oak Park

ILLINOIS MEDICAL RECORDS ASSOC.
David T. Petty, Chicago

MD COMMITTEE ON OPTOMETRY
Samuel Schall, Chicago

STATEWIDE COOPERATING ORGANIZATIONS OF THE COMMISSION ON CHILDREN
Daniel Pachman, Chicago

ILLINOIS CANCER COUNCIL
William M. Lees, Lincolnwood

CITIZENS COMMITTEE FOR AN ILLINOIS PROGRAM TO CONTROL HIGH BLOOD PRESSURE
David Littman, Glencoe

U.S. PHARMACOPAEIA
Joseph Skom, Chicago

---

The Illinois State Medical Society has developed the council and committee structure to facilitate the activities and responses of its members. Council and committee members are selected annually, based on suggestions and nominations of trustees, delegates, and county medical societies. Appointments are made by the Chairman of the Board of Trustees, with approval of the Board.

Please notify your trustee if you wish to be considered for appointment. The various activities are as listed in the Reference section. Members who wish to notify Chairman of the Board of their availability can clip and submit the coupon below.

---

NAME: _____

ADDRESS: _____ CITY: _____ ZIP: _____

TELEPHONE: (  ) _____

COUNTY MEDICAL SOCIETY: _____

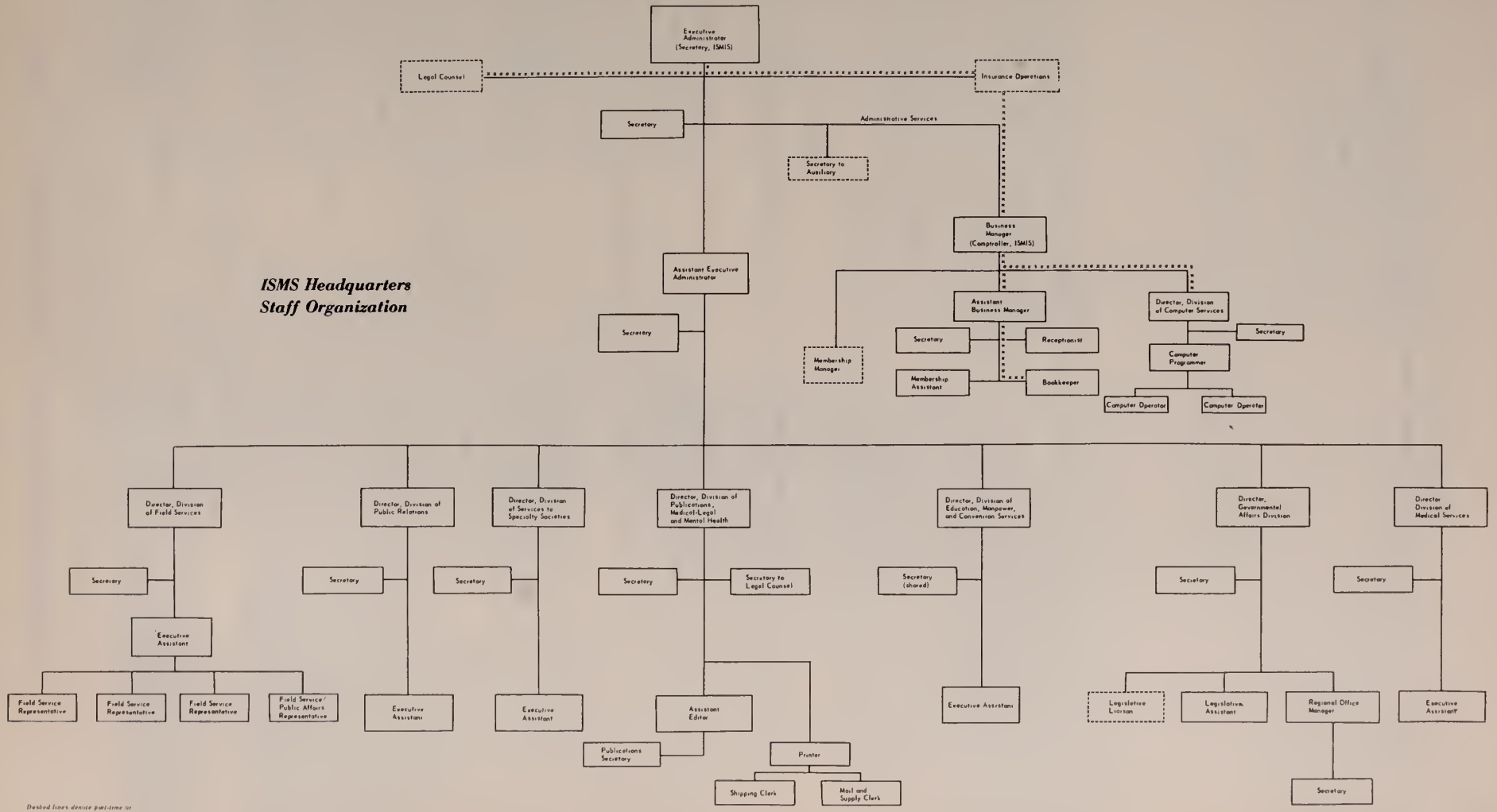
MEDICAL SPECIALTY AND TYPE OF PRACTICE _____

COMMITTEE IN WHICH INTERESTED: _____

EXPERTISE FOR THIS COMMITTEE: _____

SEND TO: Chairman, Board of Trustees, Illinois State Medical Society
55 E. Monroe, Suite 3510, Chicago, IL 60603

# *ISMS Headquarters Staff Organization*




*Dashed lines denote part-time or contractual personnel*

*x x x Allocated services in ISMIS*

# ISMS SERVICES

## Pursuit of Obligations

CONSTITUTIONAL PURPOSES OF THE ILLINOIS STATE MEDICAL SOCIETY ARE:

- to promote the science and art of medicine
- to protect the public health
- to evaluate standards of medical education
- to unite the medical profession behind these purposes
- to unite with similar organizations in other states and territories of the United States to form the American Medical Association.

The Society shall inform the public and the profession concerning the advancements in medical science and the advantages of proper medical care.

To fulfill these purposes, the Society maintains a headquarters office at 55 East Monroe St., Suite 3510, Chicago, and an office in Springfield at 701 S. Second St. Services of the Society, under the general supervision of Roger N. White, Executive Administrator, are conducted by the following divisions:

Administration; Public Relations and Membership Services; Governmental Affairs; Publications, Medical Legal and Mental Health; Education, Manpower, and Convention Services; Medical Services, Field Services, Computer Services and Services to Specialty Societies.

Many and varied are the activities of the Society in pursuit of its obligations. Some of these activities are major programs of statewide (and sometimes national) interest for all citizens; others are of special interest to doctors; still others are sponsored for specific groups or individuals.

Following are general descriptions of the Society's divisions and the programs, services and publications available directly to Society members or sponsored for their benefit.

Specific areas of responsibility and staff assignments will be identified to any member upon request.

## DIVISION OF ADMINISTRATION

The Executive Administrator has the responsibility and the authority to provide for the smooth and efficient functioning of the Illinois State Medical Society.

The implementation of established policy, fiscal and budgetary matters, the employment of qualified personnel and the development and maintenance of personnel policies are all part of the Administrator's activities.

He maintains liaison with the Board of Trustees and assists the chairman in carrying out his duties. Close cooperation with the Speaker of the House of Delegates and the officers of the Society provides a smooth and efficient atmosphere in which the Society may function. Cooperation is maintained with the Committee on Constitution and Bylaws to present to the House all suggested changes for official action. The Administrator channels all legal inquiries and works with the General Legal Counsel to provide guidance to the officers, trustees, committee chairmen and county medical society officers.

The headquarters office has been organized by divisions to provide the membership of the Society with the best professional staff services available.

The Assistant Executive Administrator serves within this Division as a coordinator for programs of the state society. Further coordination between programs of the State Society and the County Medical Societies is achieved through Field Services Representatives.

The accounting and business service functions of the Society are handled by the Business Manager as a part of this Division. The Division also maintains the membership records and provides a computerized central dues billing and collection center for county medical societies. The Society's accounting and membership records are handled in close coordination with the Secretary-Treasurer under policies laid down by the Finance Committee and the Board of Trustees.

## DIVISION OF COMPUTER SERVICES

This Division was established in 1976 as a result of the Board of Trustees authorization to purchase a computer for the purpose of cataloging claim statistics in conjunction with the Hartford Liability Insurance program, sponsored by ISMS. Computer requirements were soon increased when the doctor-owned Insurance Exchange was established that same year. Insurance Services currently uses ISMS hardware and operations for its broad variety of problems.

Computer services are provided internally to ISMS for its centralized membership dues billing and collection system, financial record keeping and label production for the many Society mailings. A physician data base is currently being assembled as an information source for our councils and committees.

The Computer Service Division is being organized to provide limited time sharing arrangements and services to outside organizations. As we complete internal projects we shall seek further users in our effort to continue a cost effective system.

## DIVISION OF EDUCATION, MANPOWER AND CONVENTION SERVICES

The Division of Education and Manpower was established in response to the growing demands created by the rapid changes in the education and utilization of physicians and other health care personnel. A primary responsibility of the Division is to maintain information on the changes in medical education. The Division works in concert with the AMA in keeping abreast of changes in medical school curricula, and in postgraduate medical education.

In addition, the Division attempts to maintain current information on the training and use of such ancillary personnel as nurse practitioners and physician's assistants. New and innovative use of personnel are studied and recommendations made to the ISMS Board of Trustees as to their appropriateness and legality. All information maintained by the Division is, of course, available to all ISMS members.

The Division maintains liaison with the Department of Registration and Education to ensure that any licensure problems may be handled expeditiously. It is also responsible for coordinating meetings and conventions for all divisions, as well as the services and arrangements incident to the annual and interim sessions and provides staff services and the Resident Physicians Section, Student Business Session, and the American Association of Medical Assistants, Illinois Society.

## DIVISION OF FIELD SERVICES

The primary responsibility of Field Services is to provide liaison, service and education to the Society's membership through Field Service Representatives. Each Field Representative has the responsibility for liaison with component societies, allied professions and government agencies, to insure State Society representation and to provide a means for communication; service to the trustees, officers, executives, general membership and county medical societies; to provide a constant update on ISMS information, programs and resources; and education to the general membership through the distribution of a wide variety of issues affecting the practice of medicine.

Specific areas of activity include health planning, President's Tour, Trustee District meetings, the legislative Key-Man program, public affairs activity, Medicaid and Medicare membership services, audit assistance, and CHAMPUS professional relations.

Additional division activities include staffing the Third Party Payment Processes Committee, which deals with Medicaid matters; the Health Planning Committee, which closely follows the activities of the State Planning Agency, Statewide Health Coordinating Council, Illinois Health Facilities Planning Board and local Health Systems Agencies; and the Public Affairs Committee, which conducts activities designed to educate physicians about the political process.

Staff of the Division attend meetings of governmental and professional organizations involved in the above described areas and participate in hearings and programs used to develop policy and programs regarding these issues.

## GOVERNMENTAL AFFAIRS DIVISION

As professional medicine strives to maintain the vigorous condition of the public health, the profession is vitally and intimately concerned with legislative actions of the Illinois General Assembly and the U. S. Congress which affect physicians, other members of the healing arts, and the lay public. To insure that the best health interests of the public and professional interests of the physician are served, the Division monitors all state and national legislation which affect the health of the individual and his community.

The monitoring process is designed to present the thoughtful views of professional medicine in Illinois on specific medically-related pieces of legislation.

The ISMS Governmental Affairs Council acts as the clearing house for legislative proposals recommended by specialized ISMS committees; generated by allied groups; produced by special interests and introduced by representatives and senators. Such legislation is thoroughly analyzed by physician-members of the specialized ISMS committee covering the subject matter of the introduced legislation.

**Support or Oppose Legislation**

Upon appropriate consideration and recommendation, legislation of medical significance in the Illinois Legislature is either supported or opposed to protect and promote the interests of the public and the profession. Pertinent subject matter testimony is presented before the House and Senate committees as the bill proceeds through the legislative process.

On-the-scene surveillance of monitored legislation is maintained by ISMS legislative representatives.

Through these essential actions, ISMS plays a meaningful role in shaping legislation for the betterment of the people of Illinois.

Action similar to the above is taken with respect to bills in Congress when they have special significance to Illinois physicians. This activity is conducted in concert with the American Medical Association.

**Other Activities**

The division also staffs the Ad Hoc Eye Health Committee.

# DIVISION OF MEDICAL SERVICES

To respond to the social and economic issues facing physicians, the Division of Medical Services has the responsibility for conducting ongoing liaison activities with various public, governmental, professional and private organizations. Through the Council on Economics and Peer Review, and the Council on Medical Services, the Division reviews current subjects affecting the physician and his relationships with patients, medical facilities, public health programs, and health insurance carriers. The products of council meetings may take the form of educational seminars, informational materials, legislation, or position statements.

The Division is also responsible for staffing the ISMS Committee on Insurance—which monitors the Society's sponsored insurance programs for the membership—and the Ethical Relations Committee, which conducts disciplinary procedures in accordance with Chapter XI of the ISMS Constitution.

**Council on Medical Services**

This council studies issues and recommends actions relating to maternal welfare, workmen's compensation, public health, nutrition and school health programs, medical facilities, health care delivery systems and the special needs of the poor, the elderly, prisoners and those in our rural communities. Representatives from the Illinois Department of Public Health serve as consultants to the council providing the necessary expertise to participate in developing programs and policies for the public sector.

**Council on Economics and Peer Review**

Principal duties of the Council on Economics and Peer Review include keeping abreast of problems which arise out of the physician's relationships with patients and third-party payors and monitoring the peer review process in our state. These activities are the responsibility of the Council's committees on Private Health Insurance and Peer Review Appeals. Serving as consultants to the Council are representatives from the Health Insurance Association of America (HIAA) and the Illinois Blue Cross/Blue Shield Association.

**Committee on Insurance**

ISMS offers seven insurance plans as benefits to the membership. Life, Hospital Benefit, Major Medical, Excess Major Medical, Disability, Business Overhead and Worker's Compensation programs are underwritten and administered through outside organizations. These are monitored, and periodically modified, by the Committee to reflect the changing needs of the membership.

**Ethical Relations Committee**

This committee, composed of ISMS Trustees, is responsible for implementing Chapter XI, the Disciplinary section of the ISMS Constitution. It only meets when a case is appealed to the State Society following a hearing at the local or District level.

As new medical delivery systems are developed, the Division will expand its activities to prepare physicians for the inevitable changes in their practice environment.

# DIVISION OF PUBLICATIONS, MEDICAL-LEGAL, AND MENTAL HEALTH

The Division of Publications, Medical-Legal and Mental Health is charged with staff responsibility for activities associated with the Council on Mental Health and Addiction, Medical Legal Council, and the Publications Committee. Under the councils are several committees and subcommittees. In addition, liaison is maintained with many public and voluntary organizations, on a formal basis, in order to keep abreast of current developments and to ensure representation of the Illinois State Medical Society. Staff functions include various activities in professional liability, as well as work on specific problem areas allied to medical-legal concerns.

## Publications

Total production of all printed materials and publications, as well as their distribution, is this division's responsibility, except for distribution of items to selected specific groups. Printing and duplicating services are furnished either through an in-plant shop or outside services through competitive bidding.

In addition, mail room services are provided by this division. An addressograph and graphotype are utilized as well as a small wing mailer, folder and stuffer, and plate burning cabinet.

Principal among the publications of the society is the official organ, the *Illinois Medical Journal.* The *Journal* is mailed monthly to all members, as well as other selected individuals, who are urged to read it to keep abreast of the scientific, economic, political, legal and social developments within the state, as such pertain to the practice of medicine.

"Action Report" is an in-house publication totally produced in the ISMS print shop. Special publications, brochures, flyers, pamphlets, letters and cards as required by the several ISMS and ISMIS divisions to carry forth their mission, are produced.

Needs of groups affiliated with or ancillary to ISMS, insofar as reproduction or distribution services are concerned, are also handled through the division office.

## DIVISION OF PUBLIC RELATIONS AND MEMBERSHIP SERVICES

The Division of Public Relations functions both as an outlet to the news media and as a source of information for the membership.

Staff members prepare speeches, slide presentations, pamphlets and other materials on a wide range of topics to support activities of officers, councils and committees. In addition, the Division arranges press conferences and prepares news releases to publicize ISMS actions and views on major issues. Also, the Division serves as liaison to the news media, responding to almost daily requests for background information or summaries of society activities.

Beyond these traditional public relations duties, the Division conducts a number of special, highly successful projects. Among them are:

*President's Tour* . . . takes the ISMS President to each Trustee District and provides an opportunity for members to discuss with the president matters affecting medicine and the society. An integral part of the "tour" is press conferences and media interviews as well as civic club speaking engagements arranged by the division.

*Action Report* . . . is a periodic newsletter which reports on ISMS activities and major events affecting medicine.

*AID (Athletics . . . Injury and Disease)* . . . assists coaches and trainers in prevention, recognition and initial treatment of injuries and illnesses. This quarterly sports-medicine newsletter is distributed to approximately 2,000 junior and senior high school coaches and trainers in Illinois.

*Radio-TV Speaker's Bureau* . . . provides physicians to discuss general medical topics on regularly-scheduled programs. In addition, the bureau provides physician speakers for civic, fraternal, church and community groups.

*Public Service Radio Announcements* . . . providing general health information are distributed to approximately 150 Illinois radio stations.

## DIVISION FOR SPECIALTY SOCIETIES

The Division for Specialty Societies—established in March, 1978 to provide closer liaison with medical specialty organizations—provides staff services to four Illinois specialty societies with a combined physician membership of 2,800. Services also are provided to the Illinois Medical Group Management Assn., a group of 150 clinic administrators.

The Division is responsible for handling daily operations of the component groups. Its primary responsibilities may be divided into the following areas: (1) routine office management, correspondence and inquiries; (2) meeting arrangements; (3) membership promotion and record keeping; and (4) dues collection and accounting records. Division staff also handle inquiries from the general public regarding activities of the five organizations. The Division also is responsible for preparing membership newsletters for each group. Staff services are provided to the participating organizations on a cost basis.

An important function of the Division is to maintain liaison between ISMS and specialty society officers by forwarding copies of ISMS Board of Trustees abstracts, press releases and other materials to the specialty organizations. The arrangement also permits a close liaison with other ISMS divisions whose activities affect specialty society interests, such as the Division of Publications, Medical-Legal and Mental Health and the Governmental Affairs Division.

The Division also staffs the Council on Affiliate Societies. Composed of representatives from 21 Illinois specialty societies, the Council is responsible for improving communication and providing liaison with the specialty societies; providing specialty consultation to other ISMS councils and committees; and serving as a resource unit to ISMS on advances in the medical specialties.

## SPECIAL PUBLICATIONS

### Action Report

"Action Report" is a periodic newsletter published by the Illinois State Medical Society. It is distributed to members upon request. Purpose of the report is to alert physicians to important events or activities affecting the practice of medicine.

A short deadline ensures that important news is disseminated to the physicians as quickly as possible so that appropriate responses may be made.

### On the Legislative Scene

Emanating from the Springfield Regional Office is a weekly newsletter, "On the Legislative Scene," published during the weeks the General Assembly is in session.

This is produced by the Governmental Affairs Division and distributed upon request. It includes up-to-the-minute status reports on pending legislation of vital concern to medicine in Illinois. This well-received periodical has permitted immediate response by ISMS representatives in Springfield to specific bills and has alerted physicians to the need for involvement in public affairs.

## SCIENTIFIC SPEAKERS BUREAU

The Illinois State Medical Society, through its Scientific Speakers Bureau, aids county societies in their efforts to keep members abreast of medical advances by conducting postgraduate medical education programs in their own areas. This assistance includes obtaining speakers, preparing and mailing notices of meetings, and paying an honorarium and travel expenses. ISMS can also provide publicity services upon request.

It also pays a $50 honorarium and expenses for individual speakers obtained by county medical societies for their regular meetings.

The Bureau operates under a grant from Merck, Sharpe & Dohme, which provides funds to the ISMS Educational and Scientific Foundation for the specific purpose of obtaining speakers for county medical society meetings.

In February, 1978, a special adjunct to the Scientific Speakers Bureau was formed through a grant from the Illinois Department of Mental Health and Developmental Disabilities, Division of Alcoholism. That grant facilitates presentations by a special roster of speakers in alcoholism education.

The following procedures govern use of the Bureau:

1) County societies select speakers from a roster containing the names of more than 400 speakers and over 1,000 topics.

2) Publicity to media in the area of the meeting will be handled by ISMS upon request of the county society.

3) Postcard notices will be mailed to physicians in the county if requested. ISMS will prepare and mail notices if the information is received no less than three weeks prior to the meeting.

4) The county medical society program chairman and the speaker are both expected to submit to ISMS a report on the meeting and the arrangements.

## PHYSICIAN RECRUITMENT & STUDENT LOAN FUND PROGRAMS

The Illinois State Medical Society not only offers help to students who wish to become physicians, but also is able to assist the careers of those already licensed to practice medicine.

The society provides this aid through two special activities. First is its own Physician Recruitment Program & Doctor's Job Fair. Second is the Illinois Medical Student Loan Fund Program that the society sponsors in conjunction with the Illinois Agricultural Association.

### PHYSICIAN RECRUITMENT PROGRAM

The Physician Recruitment Program is designed to help physicians find a desirable area in which to establish practice or to relocate. The program's purpose is twofold, since it is interested also in helping those communities which demonstrate need of a physician.

More than 600 medical doctors have been placed through this program since its inception shortly after World War II.

The Physician Recruitment Program maintains an up-to-date listing of some 125 "open" areas needing physicians.

This service accepts requests from both physicians and communities for placement. In addition, physicians are referred to the service by a number of organizations, among them the American Medical Association and the Illinois Agricultural Association. Frequently, responsible citizens or overburdened physicians in a community will contact the service.

The Physician Recruitment Program sends a questionnaire to the applicant physician to obtain information on his educational background, his interests and preferences of type of practice. Upon return of the questionnaire, the physician is sent a complete list of openings. Each opening is detailed on its facilities for home life, office space, proximity to hospital facilities and other specifics.

The Physician Recruitment Program offers its assistance to all qualified physicians who request it. An applicant need not be a member of the state medical society.

Another important function of the Physician Recruitment Program is to assist small communities in developing programs to attract physicians such as the Doctor's Job Fair.

### ILLINOIS MEDICAL STUDENT LOAN FUND PROGRAM

The Illinois Medical Student Loan Fund Program is designed to help those who have what it takes to become a physician, but lack sufficient financial resources or a recommendation for medical school.

Loans to students in need are provided by a joint contribution from the Illinois State Medical Society and the Illinois Agricultural Association. The program offers loans up to $750 per semester for four years. The total amount of loan funds available varies from year to year, depending on repayments into the revolving fund. The amount of each individual loan is determined by the student's current financial need. A low interest rate is charged from the time the loan is received. The borrower also must insure himself for the entire amount of the loan and pay premiums on the policy. Repayment begins January 1 of the fourth year following medical school graduation.

The program also offers assistance to those who may not have financial difficulties, but are denied matriculation into medical school because their college grades or Medical College Admission Test (MCAT) scores are marginal. The board representing the sponsoring organizations of the program can recommend candidates annually to the Uni-

versity of Illinois College of Medicine. After careful screening to determine whether the applicant has the potential to make a good medical student, the board can recommend him for admittance on the basis of its investigation.

In return for this assistance from the Medical Student Loan Fund Program, the applicant must agree to practice medicine in an Illinois town serving a rural population. Minimum practice time is:

(1) Freshman student receiving recommendation—five years of practice.

(2) Freshman student receiving financial assistance for four years—four years of practice.

(3) Upper classman already in medical school—one year of practice for each year that financial aid is taken (one year minimum).

The applicant may select a practice location of his own choice, provided it is in a community that has a demonstrated physician shortage. The choice is subject to approval by the program's board. The purpose of this agreement is to provide physicians for the rural communities of Illinois.

To be considered for assistance from the Medical Student Loan Fund Program, an applicant must be recommended by the presidents of his home county medical society and farm bureau. Rules of eligibility require that an applicant be a premedical student of at least three years college standing; applicants must also complete the required American Medical College Admission Service forms. This AMCAS application must be on record with the University of Illinois Medical School by November 1. Illinois residency is required.

The board of the Medical Student Loan Fund Program conducts an annual interview meeting for those students who wish to enter medical school the following September. Students qualifying for the interview are notified and invited in mid-November. Those approved for assistance are accepted on a comparative and competitive basis. Information and applications may be obtained from Roy E. Will, Manager, Medical Student Loan Fund Board, 1701 Towanda Ave., P.O. Box 2901, Bloomington, IL 61701.

## IMPARTIAL MEDICAL TESTIMONY

The Impartial Medical Testimony program, in which the Illinois State Medical Society participates, is designed to elicit objective medical truth and facilitate the equitable disposition of cases in the courts of Illinois.

As a technique of judicial administration, impartial medical testimony examiners are ordered by the court when there is divergence of medical opinion in litigation before the court. An IMT examination provides the court with objective, impartial medical data and opinion.

The Illinois State Medical Society played a significant role in the creation and development of the IMT program.

The panel of impartial medical examiners is comprised of physicians who are grouped into medical specialties. Composition of the panel is reviewed periodically to maintain the highest standards for the courts of Illinois.

In 1976 the functions of IMT were expanded to provide service to the Supreme Court Attorney Registration and Discipline Commission.

## SPONSORED COMMERCIAL INSURANCE PROGRAMS

### Hospital Benefit Plan

The Hospital Benefit Plan, approved by the Board of Trustees March 14, 1971, is available exclusively as a benefit to ISMS members. The society will incur no expense as a result of sponsoring this voluntary program.

The Hospital Benefit Program consists of three plans. Plan A provides $25 per day, Plan B provides $50 per day and Plan C provides $100 per day for each day you are confined in a hospital as an in-patient because of an accident or sickness for as long as one year. Benefits are provided from the first day of in-patient hospital confinement in any general hospital which has available 24-hour nursing services and has facilities for major surgery.

All active members of the society, their employees and their families are eligible for participation during enrollment periods conducted by the Administrator, Robinson Administrative Services, Inc., 209 S. LaSalle St., Chicago 60604.

The daily benefits are automatically doubled for all participants under age 65 for hospital confinement due to cancer or hospital confinement in an intensive care unit.

The plan pays regardless of any other insurance policies members have, and in addition to Medicare and Social Security benefits. Benefits are paid directly to the participant and not to a doctor or hospital, unless assigned. Benefits are not taxable and therefore need not be included in one's tax return.

The coverage is limited to sickness which commences or accidents which occur while the insurance is in force. However, conditions pre-existing the effective date of insurance will be covered if the participant has not received treatment or medical advice during any period of 12 consecutive months ending after the effective date of insurance. After two years from the effective date of insurance, coverage is guaranteed regardless of any pre-existing conditions.

The plan includes these exclusions: war or act of war, service in the armed forces of any country or international authority at war, pregnancy (including childbirth or resulting complications), or intentionally self inflicted injuries, suicide or attempted suicide, whether sane or insane.

Enrollment forms and details about the plan can be obtained by calling the Administrators Office, collect, at (312) 726-2575.

### Group Disability Program

The Group Disability Program has been available to members since 1947. All eligible members of ISMS may apply if under age 55 and regularly attending all of the usual duties of their profession. The coverage is renewable to age 70 and offers three choices—Lifetime Accident and (1) Sick-

ness payable to age 65, (2) Sickness payable for 7 years, (3) Sickness payable for 1 year.

New members under age 40 joining ISMS may enroll without evidence of insurability for up to $400.00 per month. Benefits under Plan I, (lifetime accident, 1 year sickness). The plan offers up to $1732.00 per month benefits to members under 50 and $1300.00 per month benefits to members under age 55.

Benefits of the program are payable regardless of any other insurance and no restrictive riders may be attached after issuance. The master contract contains a special renewal condition whereby the individual coverage cannot be terminated.

The program is explained in detail in a brochure which is available by writing to the administrator, Parker, Aleshire & Co., 9933 Lawler Ave., Skokie 60077.

## Excess Major Medical Plan

This Plan has been available to members since 1975. It is a coverage designed for the truly catastrophic accident or illness condition. The plan provides up to $500,000 for medical expenses. It is available with a $15,000, $20,000 or $25,000 deductible which supplements any Basic Major Medical Plan. It may be obtained without evidence of insurability. You have 36 months to accumulate the deductible and then the benefits are paid on a 100% basis for up to 10 full years.

For additional information, please contact the Administrator, Parker, Aleshire & Company, 9933 Lawler Avenue, Skokie, Illinois 60077.

## Workers' Compensation Insurance

The Dodson Savings Plan has been approved by the Illinois State Medical Society as a proven way to reduce the cost of Workers' Compensation insurance when claim costs are held to a minimum.

Savings for physicians in other areas such as Minnesota have frequently been 40% or more. Returns under this plan depend on the cost of claims from physicians who are insured. Policies are issued by Casualty Reciprocal Exchange, a member of the Dodson Insurance Group, and are standard in all respects. Rates are standard and approved for this class of employment. Savings are best when safety is maintained in all job related activities.

Savings are paid as earned within about 90 days after policy expiration or when payroll audits are completed.

For further details write or call collect to the managers, Dodson Insurance Group, P.O. Box 559, Kansas City, MO 64141. Phone 816-361-3400.

## Group Major Medical Expense Plan

The $25,000 Group Major Medical Expense Plan designed for the Illinois State Medical Society has been in force since 1958. It has a 20% co-insurance feature with a $500 or $1,000 deductible, whichever the physician selects. For hospital room and board, the Plan will pay up to $100 a day and in addition up to $150 a day in an intensive care unit. It will pay $20 a day in a convalescent home following release from a hospital up to 90 days. The Plan also provides maximum coverage for the insured in the event of mental illness and up to $2,000 for dependents. It will also cover a congenital abnormality from the first day of birth after the effective date of the contract up to $2,000.

New members joining ISMS will be allowed to enroll without evidence of insurability or health statement under age 40 within six months after notification of the Plan's availability.

The Group Major Medical Expense Plan is outstanding and will provide members with protection against catastrophic illness.

Further information may be obtained from the administrator, Parker, Aleshire & Co., 9933 Lawler Ave., Skokie, Ill. 60077.

## Business Overhead Expense Group Plan

This plan has been available since 1973. Today, more than ever, maintaining a medical office is costly when one considers the increasing cost of rent, employee's salaries, accountant services, utilities, etc. The sole purpose of the Business Overhead Expense Group Plan is to step in and take care of overhead expenses during a period when the physician is totally disabled as a result of an accident or illness. In the event of a serious accident or illness, the physician can keep his office open and retain his personnel with the expenses being taken care of by the Business Overhead Expense Group Plan. This Program is not to be confused with the Group Disability Plan which provides an earned income for physician to meet his personal obligations for the maintenance of his home and family.

Monthly benefits are available up to $3,500.00 with attractive premiums. Benefits commence on the first day provided total disability lasts one (1) month or longer. It will continue while totally disabled for as long as 24 months for any one accident or period of sickness. The premiums for this particular type of coverage constitute business expenses and are deductible under Internal Revenue Service Ruling (55-264, I.R.B. 1955-19, p. 8).

Further information may be obtained from the administrator, Parker, Aleshire & Co., 9933 Lawler Ave., Skokie, Ill. 60077.

# Personal Life Insurance Program

A guaranteed renewable term life insurance program, recommended by the Insurance Committee and approved by the Board of Trustees in 1972, is available to ISMS members in amounts ranging from $10,000 to $200,000. Features of the program include guaranteed future purchase options, guaranteed conversion privilege up to age 70, optional family insurance benefits, double indemnity and disability waiver premium.

Dividends are applied against premiums and reduce member's cost.

For applications and further details, contact the administrator: A. W. Ormiston & Co., 175 W. Jackson Blvd., Chicago 60604; phone 312-922-3952.

# Ancillary Organizations

## Illinois State Medical Society Auxiliary

### Growth Patterns for 1978-79

It has been said that "two women with a cause and a letterhead can produce stark terror in the hearts of sophisticated corporate heads."

With that thought in mind, one can envision the built-in potential of our state medical auxiliary for achievement. This is yet more valid when the calibre of its members and worth of its goals are taken into account.

Illinois is one of the few states with an increase in auxiliary membership. Our on-going community action projects include CPR training in the schools, Immunization Awareness and Education, Safety for the Elderly and the Vial of Life program. Our cooperative efforts with the Cancer Society and Illinois Heart Association are further evidence of involvement and interest in the quality of life in our state.

It seemed only natural that we choose "Fifty-One to Grow on" as our theme this year. We boast a newly organized county and give a warm welcome to Coles-Cumberland. That is growth, indeed; growth of the very best kind.

Each organized county has now filled the position of president-elect. Each president-elect is eligible to participate in the leadership training sessions given in Chicago every October. It would be difficult to describe the excellence and effectiveness of "Leadership Confluence."

Since the inception of the fall conference concept five years ago, interest has grown to engender the possibility of regional conferences. We have scheduled two this year, in order to test the merit of that idea.

Our September 19 Fall Conference-North gave emphasis to the fact that we are not interested solely in the concerns of children, but also in the family as a whole. Our youth cannot blossom and mature unless nurtured in a healthy, balanced environment, and the core of that environment must be a warm, harmonious home.

The broad range of subjects touched upon at the workshop included parenting—how much substitution can there be without harm? Personal responsibility for health was discussed. Dr. Nelson J. Bradley of the ISMS Panel for the Impaired Physician discussed the successful family treatment approach to alcohol and drug-related problems.

The auxiliary presented a new legislative film entitled "A Critical Difference" to those assembled. It was produced by the legislative department of the AMA, and our members were urged to make full use of this effective tool during the coming months. It will be available for all, and is designed for non-medical persons in our communities.

Fall Conference-South is scheduled for Thursday, November 9th, at the Ramada Inn, St. Clair Square in Belleville, Illinois. Cost Containment is on the agenda, along with reports from Leadership Confluence.

At this point, our future lies before us. There are endless opportunities for challenge and growth, as we work to leave the youth and families of Illinois enriched and restored through auxiliary's efforts over the next several months.

Mrs. Earl V. Klaren
*President*

### OFFICERS

President .....Mrs. Earl V. Klaren, Libertyville
President-Elect .....Mrs. R. S. Hoover, Lake Forest
1st Vice-President
(Membership) .....Mrs. Harlan Failor, Champaign
2nd Vice-President
(Programs) .....Mrs. Donald Hinderliter, Rochelle
3rd Vice-President
(Communications) ....Mrs. Harold Keegan, Kankakee
Secretary .....Mrs. Julian Buser, Belleville
Corresponding Secretary..Mrs. Homer Goldstein, Deerfield
Treasurer .....Mrs. Robert Webb, Edwardsville

### DIRECTORS

Mrs. Edward Szewczyk, Belleville
Mrs. William Hodges, Kankakee
Mrs. Jaime L. Gomez, Danville

### EXECUTIVE SECRETARY

Mrs. Robert Swanson
104 E. Broadway, Suite 5, Monmouth 61462

### COMMITTEE CHAIRMEN

AMA-ERF Chairman .....Mrs. Selig Hodes, Forreston
AMA-ERF Co-Chairman ....Mrs. Karl Reddies, Freeport
Archives .....Mrs. Ashvin K. Patel, Bloomington
Benevolence .....Mrs. August Martinucci, Joliet
Bylaws .....Mrs. Wilson West, Belleville
Community Health .....Mrs. James Gwaltney, Quincy
Communication .....Mrs. Harold Keegan, Kankakee
Convention .....Mrs. Morrison Beers, Lake Forest
Convention
Co-Chairman .....Mrs. Luben Atzeff, Lake Forest
Editorial .....Mrs. Eugene Vickery, Lena
Family Health .....Mrs. Morris Friedell, Chicago
Finance .....Mrs. Reuben Gaines, Wayne
Health Education and
Health Manpower .....Mrs. Gamil Arida, Joliet
Hospitality .....Mrs. H. Frank Holman, Belleville
Hospitality
Vice-Chairman ....Mrs. Elwood Kortemeier, Freeport
International Health ....Mrs. Eugene Leonard, Rockford
Legislation .....Mrs. Byron Weisbaum, Springfield
Membership .....Mrs. Harlan Failor, Champaign
Members-at-Large ...Mrs. Robert Hartman, Jacksonville
Program .....Mrs. Don Hinderliter, Rochelle
Public Affairs .....Mrs. David Clark, Aurora
Safety .....Mrs. Irvin Blumfield, Alton

#### SPECIAL COMMITTEES

Ad Project .....Mrs. Reuben Gaines, Wayne

Convention Guidebook
Revisions .....Mrs. Edward Szewczyk, Belleville
Convention Guidebook Revisions
Co-Chairman .....Mrs. H. Frank Holman, Belleville
Spouses of Physicians in
Training .....Mrs. Edward Szewczyk, Belleville
Editorial .....Mrs. Eugene Vickery, Lena
Co-Chairman .....Mrs. Morrison Beers, Lake Forest
Contributing Reporters .....Mrs. Irving Frank, DeKalb
Mrs. Luben Atzeff, Lake Forest
Mrs. Harold Keegan, Kankakee
Fall Conference North
Co-Chairman .....Mrs. Roberto Arellano, LaSalle
Fall Conference South
Co-Chairmen .....Mrs. Andrew Gregowicz, Belleville
Mrs. Thomas Meirink, Belleville
Long Range Planning ..Mrs. R. S. Hoover, Lake Forest
Mrs. Robert Richardson, Peoria
Mrs. P. S. B. Sarma, Wilmette
Mrs. Nicholas Borden, Flossmoor
Mrs. Willard Scrilvner, Belleville
Pseudo-Religious Cult
Awareness .....Mrs. George Olander, Lake Forest
Social Services for Benevolence
Recipients .....Mrs. Mitchell Spellberg, Chicago
Legislative Key
Women ..Mrs. Byron Weisbaum, Springfield, Chairman
Mrs. Albert Ray, Joliet
Mrs. Morrison D. Beers, Lake Forest
Mrs. Edward Dutka, Aurora
AMAA North Central Region AMA-ERF
Chairman .....Mrs. Edward Szewczyk, Belleville
Parliamentarian .....Mrs. Francis Graff, Freeport

**REPRESENTATIVES TO ISMS COUNCILS AND COMMITTEES**

Benevolence .....Mrs. August Martinucci, Joliet
Mrs. Earl V. Klaren, Libertyville
Governmental Affairs ..Mrs. Byron Weisbaum, Springfield
Mental Health and
Addiction .....Mrs. Harold Keegan, Kankakee
Public Affairs .....Mrs. David Clark, Aurora
Public Relations &
Membership .....Mrs. Harlan Failor, Champaign
Medical Services .....Mrs. James Gwaltney, Quincy

## DISTRICT COUNCILORS

2. Mrs. Louis Tarsinos, Princeton
3. Mrs. Jack Clemis, Wilmette
4. Mrs. Charles Koivun, Moline
5. Mrs. Robert Reardon, Bloomington
6. Mrs. Robert Kooiker, Jacksonville
7. Mrs. William Simon, Decatur
8. Mrs. James Laidlaw, Champaign
9. Mrs. James Heersma, Mt. Vernon
10. Mrs. Andrew Gregowicz, Belleville
11. Mrs. Alex Spadoni, Hinsdale
12. Mrs. John Leonard, Roscoe

# American Association of Medical Assistants Illinois Society

The American Association of Medical Assistants is a national, non-profit organization dedicated to the professional advancement of medical assistants. This tri-level structure—similar to AMA—encompasses local, state and national affiliation.

Membership in the Illinois Society, AAMA, is open to medical assistants, office nurses, technicians, secretaries, bookkeepers and clerks performing administrative and/or clinical duties under the direct supervision of a physician. College students attending Medical Assistant Programs are encouraged to belong. Physician advisors at all three levels assist with educational endeavors.

The state society's numerous professional, educational programs in various parts of the state offer continuing education units (CEU) to its participants. Some of the major programs are:

Traveling Course Regional Seminars, Annual Symposium, Personal Development Day and the All Day Workshop held in conjunction with Chicago Medical Society's Midwest Clinical Conference. The Annual three day meeting in April includes excellent lectures, study programs and the culmination of association business during the House of Delegates Session.

The American Association of Medical Assistants encourages advancement of medical assistants by offering a certification examination designed to evaluate professional competency. Local chapters, in addition to their regularly scheduled monthly educational programs, conduct preparatory classes in terminology, physiology, anatomy, human relations, patient contact, medical law and ethics, communications, bookkeeping, insurance, administrative procedures, laboratory orientation and collection methods. The certification examination is administered twice a year.

The medical assistant may become a Certified Medical Assistant (CMA) by successfully passing the special board examination and meeting qualifying criteria of the American Association of Medical Assistants. Specialty examinations are given in Administrative, Clinical and Pediatric divisions. For further information about this program contact the American Association of Medical Assistants, One East Wacker Drive, Chicago, Illinois 60601.

Members interested in independent continuing education through a "home study" program may purchase and utilize audio cassettes and workbooks. The president of the Illinois Society communicates, via the "Executive Memo" (a monthly publication), with nearly 1,000 mem-

bers giving pertinent information of current activities.

A quarterly publication "The Illini Cardinal" concentrates on educational topics and is available to all members without additional cost. "The Professional Medical Assistant," the official bi-monthly journal of the association, is largely devoted to original articles written for medical assistants by their peers or other professionals in related fields. It is an automatic benefit of membership, although subscriptions are available for non-members. There are many other benefits available (i.e. group insurance). During the Annual Meeting of AAMA each fall, a variety of experts in medical and related fields address participants during educational programs and workshops.

Monthly educational meetings are scheduled in the following chapers: Cook County-Chicago (downtown), Southwest Suburban (Oak Lawn), Northwest (Arlington Heights), Northshore (Skokie), West Cook (River Grove), Cook County South (Dolton), Aux Plaines (Oak Park), DuPage (Wheaton), Coles-Cumberland (Charleston), DeKalb (Sycamore), Jefferson-Hamilton (Mt. Vernon), Kane (Elgin), LaSalle, Macon (Decatur), McLean (Bloomington), McHenry, Morgan-Scott (Jacksonville), Randolph (Chester), Rock Island, Sangamon (Springfield), St. Clair (Belleville), Spoon River Valley (Canton), Vermilion (Danville), Will-Grundy (Joliet), Shawnee (Harrisburg). Physicians in these areas are asked to encourage their medical assistants to join the association and actively participate in the selection of educational programs that will enable the members to become better medical assistants.

For membership information please contact Mrs. Leslie Lee, President, Illinois Society, AAMA, 5826 N. Whipple, Chicago, IL 60659.

### OFFICERS

President—Mrs. Leslie Lee, Chicago
President-Elect—Mrs. Cissy (Moran) Egly, CMA, Joliet
Immediate Past President—Mrs. Vivian Kraft, CMA-AC, Bloomington

First Vice President—Mrs. Jean Lockenvitz, Bloomington
Second Vice President—Mrs. Anna Albert, Chicago
Recording Secretary—Ms Judith A. Miller, CMA-AC, Itasca
Corresponding Secretary—Mrs. Linda (Katek) Blazer, Chicago

Membership Secretary—Ms Mary Frances Burton, Chicago
Treasurer—Mrs. Patricia A. Mooney, R.N., Galesburg
Speaker of the House—Mrs. Luella Mitchell, Chicago
Vice Speaker of the House—Miss Pauline Klarich, Peoria
Parliamentary Advisor—Ms. Norma Domanic, LPN, New Lenox

Chaplain—Mrs. Florence Peery, CMA, Chicago
Chairman, Board of Trustees—Mrs. Ruby Jackson, CMA, Chicago

Education Chairman—Mrs. Vivian Kraft, CMA-AC, Bloomington

Publicity—Mrs. Magda Brown, Skokie

### Physician Advisors

John L. Wright, M.D., Bloomington, *Chairman*
Allison L. Burdick, Sr., M.D., Chicago
Thomas R. Harwood, M.D., Chicago
Leslie Schwartz, M.D., Chicago
Robert Hartman, M.D., Jacksonville
J. M. Ingalls, M.D., Paris, *Liaison to ISMS*

# The Educational & Scientific Foundation

The Educational & Scientific Foundation was founded to provide an administrative agency to foster the advancement of clinical science through:

1) The initiation of scientific and medical research activities.

2) The collection, evaluation and dissemination of the results of research activities to the public.

3) The implementation and management of projects related to medicine for individuals, or organizations seeking to inform or educate others, or to improve their own knowledge.

The Foundation is a distinct corporate entity which has an interlocking Board with the Illinois State Medical Society. It is staffed through ISMS headquarters.

### Board of Directors

George T. Wilkins, Granite City, *Chairman*
Audley F. Connor, Jr., Chicago
David S. Fox, Chicago
Robert R. Hartman, Jacksonville
P. John Seward, Rockford

STAFF: Division of Education, Manpower and Convention Services.

# Illinois Council on Continuing Medical Education

This Council was created by the Illinois State Medical Society, in co-operation with the state's eight medical schools, to fulfill six purposes: (a) make readily available to all Illinois physicians CME programs that will enhance patient care; (b) catalog and co-ordinate existing programs to eliminate wasteful duplication; (c) encourage development of new CME methods, techniques, and systems; (d) help identify the learning needs of Illinois physicians; (e) seek out potential CME providers and serve as liaison between producers and consumers; and (f) encourage Illinois physicians to participate in formal CME programs.

ICCME was proposed by Dr. Edward W. Cannady in his 1969 inaugural address as President of ISMS. Following careful study, the 1970 House of Delegates approved the plan in principle. The next President, Dr. J. Ernest Breed, vigorously pursued the idea; after the 1971 House of Delegates voted initial funding, he also served as Chairman of the Organizing Committee. The Illinois Association of Osteopathic Physicians & Surgeons also offers financial support for ICCME.

ICCME was officially chartered by the state as a non-profit educational organization in May, 1972, and began operations with the appointment of its first Executive Director in September, 1972.

ICCME is unique in three respects: (1) it is the only such organization supported by a state medical society and staffed by a full-time professional educator; (2) it unites the educational resources of the Illinois State Medical

Society and the state's medical schools; *and* (3) independent in action, it serves *all* interests concerned with CME and thus provides a crucial channel of communication to co-ordinate the efficient use of all available resources.

*Current Major Activities:*

1. Sponsor an annual Congress on Continuing Medical Education, to involve all elements of the Illinois health-care system in the Council's work. The fifth Congress meets April 21-22, 1978.
2. On behalf of ISMS, perform staff work for accreditation of intra-state CME including advice on preparing to apply for accreditation.
3. Advise hospitals and other organizations on effective CME—both informally and through the "Illinois Hospital CME Consultation Service."
4. Organize workshops on techniques of CME — including an unusual "Workshop on CME Leadership" for leaders of hospital medical staffs and medical societies.
5. Develop and publish CME planning aids that offer practical advice and important background on effective organization of CME. Included are *Your Personal Learning Plan,* a unique handbook offering advice on how to plan your learning most effectively; and *How to Start a CME Program in Your Hospital or Medical Society* for CME planners. For all items now available, request "The Illinois Handbooks on CME Planning—Catalog/Order Form." All publications are free to Illinois physicians-M.D. or D.O.—upon request; just write the title on your prescription form and mail to ICCME, 55 E. Monroe, Chicago, IL 60603.
6. Publish an *Illinois CME Case Compendium* for hospital CME case-discussion groups.
7. Publish a monthly calendar of Illinois CME activities for *IMJ.*

*Organization & Governance*

Members of the ISMS Executive Committee serve as legal members of the ICCME Corporation, set basic policy, and elect the Board of Directors.

The affairs, property, and business of the Council are managed by a Board of Directors comprised of: eight practicing physicians selected by the ISMS Board of Trustees; eight academic physicians, one selected by each dean of an Illinois medical or osteopathic school; plus the chairman of the ISMS Committee on CME Accreditation.

## Board of Directors

William Lees, Lincolnwood, *President*
Donald F. Pochyly, Chicago, *Vice-President*
Ward E. Perrin, Chicago, *Secretary*
George Shropshear, Chicago, *Treasurer*
Anthony L. Barbato, Maywood
Ernst Chester Bone, Jacksonville
Dean Bordeaux, Peoria
Alfred J. Clementi, Arlington Heights
Joseph Daddino, Chicago
James E. Dyson, Ph.D., Chicago
Thomas Henderson, Ph.D., Chicago
Chase P. Kimball, Chicago
Boyd McCracken, Greenville
Harold A. Paul, Chicago
Mather Pfeiffenberger, Alton
Lewis W. Tanner, Danville
D. Dax Taylor, Springfield
EXECUTIVE DIRECTOR: Leonard S. Stein, Ph.D.

## COMMITTEE ON ACCREDITATION

Dean R. Bordeaux, M.D., Peoria, *Chairman*
Philip D. Anderson, Chicago
Allan C. Campbell, M.D., Peoria
Julius S. Newman, Aurora
H. Close Hesseltine, M.D., Chicago, *Consultant*

STAFF: Illinois Council on Continuing Medical Education

**Responsibilities and Purposes:**

To review reports of institutions which have applied for accreditation of their continuing medical education activities and make recommendations to the national Liaison Committee on Continuing Medical Education. To provide liaison with the Illinois Council on Continuing Medical Education.

## ILLINOIS CME SPONSORS ACCREDITED BY THE LIAISON COMMITTEE ON CONTINUING MEDICAL EDUCATION AS OF AUGUST 31, 1978

The Academy of Cutaneous Surgery—River Forest
Alfred Adler Institute of Chicago, Inc.
Augustana Hospital—Chicago
Belleville Hospital Association for CME
(Memorial Hospital, St. Elizabeth Hospital)
Carle Foundation Hospital—Urbana
Central Community Hospital—Chicago
Central DuPage Hospital—Winfield
Chicago College of Osteopathic Medicine
Chicago Pediatric Society
Chicago Surgical Society
Christ Hospital—Oak Lawn
Columbus-Cuneo-Cabrini Medical Center—Chicago
Copley Memorial Hospital—Aurora
Cook County Hospital—Chicago
DuPage County Medical Society—Lombard
Elgin Mental Health Center
FAB³-CME (Forkosh Memorial, Belmont Community, Bethesda, Bethany Methodist, Thorek Medical Center) Chicago
Forest Hospital—Des Plaines
Grant Hospital of Chicago
Henrotin Hospital—Chicago
Hinsdale Sanitarium & Hospital

Holy Cross Hospital—Chicago
Illinois Central Community Hospital—Chicago
Illinois Council on Continuing Medical Education—Chicago
Illinois Heart Association—Springfield
Illinois Hospital Association—Oak Brook
Illinois Masonic Medical Center—Chicago
Illinois Society of Allergy and Clinical Immunology—Highland Park
Illinois Society of Ophthalmology and Otolaryngology—Danville
Kishwaukee Community Hospital—DeKalb
Little Company of Mary Hospital—Evergreen Park
Louise Burg Hospital—Chicago
Loyola University Stritch School of Medicine—Maywood
Lutheran General Hospital—Park Ridge
MacNeal Memorial Hospital—Berwyn
Manteno State Hospital
Martha Washington Hospital—Chicago
Mary Thompson Hospital—Chicago
Memorial Hospital of DuPage County—Elmhurst
Mercy Hospital & Medical Center—Chicago
The Methodist Medical Center of Illinois—Peoria
Michael Reese Hospital & Medical Center—Chicago
Mount Sinai Hospital Medical Center of Chicago
Northwestern University Medical School—Chicago
North Shore Mental Health Association/Irene Josselyn Clinic—Northfield
Northwest Hospital—Chicago
Northwest Community Hospital—Arlington Heights
Norwegian-American Hospital—Chicago
Oak Forest Hospital
Oak Park Hospital
Ravenswood Hospital Medical Center—Chicago
Resurrection Hospital—Chicago
Riveredge Hospital—Forest Park
Riverside Hospital—Kankakee
Rock Island Franciscan Medical Center
Roosevelt Memorial Hospital—Chicago
Rush Medical College—Chicago
Sarah Bush Lincoln Health Center—Mattoon
Sherman Hospital—Elgin
Silver Cross Hospital—Joliet
Skokie Valley Community Hospital—Skokie
South Chicago Community Hospital
Southern Illinois Medical Association—Belleville
Southern Illinois University School of Medicine—Springfield
St. Anthony Hospital—Chicago
St. Anthony Hospital—Rockford
St. Elizabeth's Hospital—Chicago
St. Elizabeth Hospital—Danville
St. Elizabeth—Granite City
St. Francis Hospital-Medical Center—Peoria
St. Joseph Hospital—Chicago
St. Joseph Hospital—Elgin
St. Mary's Hospital—Streator
St. Mary of Nazareth Hospital—Chicago
St. Therese Hospital—Waukegan
Swedish American Hospital—Rockford
Swedish Covenant Hospital—Chicago
Tinley Park Mental Health Center
University of Chicago Pritzker School of Medicine
University of Health Sciences/The Chicago Medical School
University of Illinois College of Medicine
Weiss Memorial Hospital—Chicago
Westlake Community Hospital—Melrose Park
West Suburban Hospital—Oak Park

# Illinois Foundation for Medical Care

The Illinois Foundation for Medical Care (IFMC) is a not-for-profit corporation established in 1971 by action of the House of Delegates. Under revised bylaws adopted June, 1977, IFMC is operated under direction of a 6-member Board of Directors elected annually by the ISMS Board of Trustees. The IFMC currently contracts with the Regional Health Resources Center, Urbana, Illinois for administrative services.

IFMC maintains relationships with the several local foundations for medical care and is available to serve their needs on a cost reimbursement basis.

## IFMC Board of Directors

Joseph Sherrick, M.D., Chicago, *President*
Robert P. Johnson, M.D., Springfield, *Vice-President*
James Laidlaw, M.D., Champaign, *Secretary-Treasurer*
Audley F. Connor, M.D., Chicago
Miller Henderson, M.D., Rockford
Lawrence L. Hirsch, M.D., Chicago

# Illinois Medical Political Action Committee (IMPAC)

The Illinois Medical Political Action Committee (IMPAC) is a voluntary, non-profit, unincorporated, permanent membership organization founded in 1960. IMPAC serves as the unified political action arm of Illinois physicians and their spouses. It cooperates with others in the healing arts professions. Funds collected through IMPAC memberships, used in support of candidates, are administered independently of other professional groups. However, the program is operated in harmony with the legislative objectives of the Illinois State Medical Society. Individual participation in IMPAC is one means by which the individual physician and his spouse can effectively participate in public affairs.

IMPAC participates primarily in election contests for legislative offices—both those in the Illinois General Assembly and in the U. S. Congress. It cooperates in membership solicitation activities with the American Medical Political Action Committee (AMPAC).

IMPAC's organization consists of a chairman, an executive committee, and a council. Political action activities are implemented by local physician support committees formed on behalf of candidates in U. S. Congressional or other legislative districts. Candidate selection and support are determined on the basis of evaluations and recommendations submitted to the council and executive committee by the local committees, thus assuring members of a "grass roots" voice in IMPAC activities.

Additional information about IMPAC may be obtained by writing: IMPAC, Suite 3510, 55 E. Monroe, Chicago 60603.

# Illinois State Medical Insurance Services, Inc.

Illinois State Medical Insurance Services is an Illinois corporation, formed in March, 1976, all of whose capital stock is owned by the Illinois State Medical Society. Its sole business is to act as Attorney-in-Fact for the Illinois State Medical Inter-Insurance Exchange.

The Exchange was organized to provide comprehensive professional liability insurance for Illinois physicians. Its membership is limited to members of the Illinois State Medical Society

Insurance Services provides all the management and underwriting services required for the operation of the insurance business of the Exchange. It does so under Power-of-Attorney granted it by the Exchange in a management agreement with an initial term of five years, and by each member of the Exchange through his application for membership. Under the management agreement the Board of Governors of the Exchange prescribes policy to be followed in the conduct of the business; within the guidelines established by these policy statements, Insurance Services manages the business of the Exchange, accepting or rejecting applications, determining the form of insurance policies, handling and disposing of claims, and performing all related functions. Insurance Services is compensated by the Exchange on the basis of expense reimbursement; it is not anticipated that Insurance Services will produce any operating profit.

The organization of Insurance Services comprises four principal functional divisions: Risk Management and Underwriting, Claims, Policyholders and Public Relations, and Administrative Services. Advisory and consultative services are provided by member physicians through a review system organized and directed by the Medical Director of Insurance Services. Financial and accounting services are provided by staff of the Illinois State Medical Society, whose Business Manager serves as Controller of Insurance Services. The offices of Illinois State Medical Insurance Services, Inc., are at 55 East Monroe Street, Suite 3440, Chicago, Illinois 60603.

**Board of Directors**

Phillip D. Boren
Alfred Clementi
Robert T. Fox
Robert Hamilton
J. M. Ingalls
Warren D. Tuttle
Roger N. White

**Officers**

Robert T. Fox, *Chairman*
Paul E. Singer, *President*
Henry Nussbaum, *Vice President*
Roger N. White, *Secretary-Treasurer*
Phillip D. Boren, *Medical Director*

# Student Business Session

Daniel R. Shirey, Maywood (Loyola) *Chairman*
W. Joseph Ketcherside, Chicago (University of Chicago) *Vice Chairman and Treasurer*
Jerry Cohen, Chicago (Northwestern) *Secretary*
David Aizuss, Chicago (Northwestern) *Delegate*
Jason Chao, Chicago (Northwestern) *Alternate Delegate*
John Johnson, Forest Park (Loyola) *Immediate Past Chairman*

**School Representatives**

Chicago Medical School
Phil Dray, Wilmette
Loyola University
Kenneth Stein, Oak Brook
Northwestern University
John Deseris, Chicago

Rush Medical School
David Fletcher, Oak Park
Southern Illinois University
David Roszhart, Springfield
University of Chicago
Don Henry, Chicago
University of Illinois
Robert Bryg, Chicago

The purposes of the Student Business Session shall be to encourage and support the active participation of medical students in the ISMS and to provide a representation of student opinions and ideals in organized medicine. In addition, the Student Business Session shall support the purposes of ISMS as stated in its constitution. The Student Business Session is composed of all student members of ISMS.

# Resident Physicians Section

Ira Isaacson, Chicago, *Chairman*
Michael Sadove, Chicago, *Vice Chairman and Treasurer*
Linda Hughey, Wilmette, *Secretary and Editor*
James DeBord, Oak Park, *Delegate*
Anthony Savino, Chicago, *Alternate Delegate*

### House Staff Organization Representatives

The Children's Memorial Hospital
Cindy Moody and Abby Adams, Chicago
Illinois Masonic Medical Center
Brett Cassens, Chicago
Illinois State Psychiatric Institute
Stephen R. Cann, Chicago
Institute for Juvenile Research
Saroj Goyal, Chicago
Lutheran General Hospital
David Cooke, Park Ridge
Peoria School of Medicine/Methodist Medical Center
Leslie E. Mathers, III, Peoria
Rockford School of Medicine/Swedish American Hospital
Dennis P. Zoller, Rockford
Rush-Presbyterian-St. Luke's Medical Center
Benjamin L. LeCompte, III, Chicago
Scott Medical Center
C. A. Schuler, Scott AFB
St. Francis Hospital (Evanston)
James Zimmerman, Evanston
St. Francis Hospital Medical Center
Richard O'Connor, Peoria
St. Joseph Hospital
William Manns, Chicago
SIU School of Medicine/Carbondale
Roger Wujek, Carbondale
SIU School of Medicine/Springfield
James Apesos, Springfield
Swedish Covenant Hospital
Ira Moskowitz, Chicago
University of Illinois Hospital
James McCreary, Oak Park
Veterans Administration/North Chicago
Krishna Venu, North Chicago

The purposes of the Resident Physicians Section shall be to encourage and support the active participation of physicians in training in the Illinois State Medical Society and to provide representation of intern-resident opinions and ideas in organized medicine. In addition, the Resident Physicians Section shall support the purposes of the ISMS, as stated in its constitution. All in-training members of the ISMS shall be members of the Resident Physicians Section, having the right to vote and hold office.

# MEDICAL AND ALLIED HEALTH EDUCATION

## MEDICAL SCHOOLS IN THE STATE OF ILLINOIS

Chicago Medical School, University of Health Sciences
2020 W. Ogden Ave., Chicago, 60612
Northwestern University Medical School
303 E. Chicago Ave., Chicago, 60611
University of Chicago-Pritzker School of Medicine
950 E. 59th Street, Chicago 60637
University of Illinois College of Medicine*
Chicago Campus—
1853 W. Polk Street, Chicago, 60612
Loyola University, Stritch School of Medicine
2160 S. First Ave., Maywood, 60153
Rush Medical College
1725 W. Harrison St., Chicago 60612
Southern Illinois University School of Medicine
801 N. Rutledge, P.O. 3926, Springfield, 62708

*Note: This is the parent college for Abraham Lincoln School of Medicine, Peoria School of Medicine, Rockford School of Medicine.

# ALLIED HEALTH EDUCATIONAL PROGRAMS
## accredited by the
## American Medical Association Committee on
## Allied Health Education and Accreditation

### CYTOTECHNOLOGIST

CHICAGO—Michael Reese Hospital & Medical Center
Mount Sinai Hospital Medical Center
University of Chicago—Lying-in-Hospital

### HISTOLOGIC TECHNICIAN

CHICAGO—Mercy Hospital & Medical Center
Mount Sinai Hospital & Medical Center
St. Joseph Hospital
University of Chicago Hospitals & Clinics
SPRINGFIELD—St. John's Hospital

### MEDICAL ASSISTANTS

BELLEVILLE—Belleville Area College
CARTHAGE—Robert Morris School
PALATINE—William Rainey Harper College
RIVER GROVE—Triton College

### MEDICAL LABORATORY TECHNICIAN

BELLEVILLE—Belleville Area College
DANVILLE—St. Elizabeth Hospital
DIXON—Sauk Valley College
EAST PEORIA—Illinois Central College
ELGIN—Sherman Hospital Association
GODFREY—Lewis & Clark Community College
MORTON GROVE—Oakton Community College
OLNEY—Richland Memorial Hospital
PALOS HILLS—Moraine Valley Community College
QUINCY—Blessing Hospital
RIVER GROVE—Triton College

### MEDICAL RECORD ADMINISTRATORS

CHICAGO—University of Illinois College of Medicine
NORMAL—Illinois State University

### MEDICAL RECORD TECHNICIAN

BELLEVILLE—Belleville Area College
CHICAGO—Central YMCA Community College
EAST PEORIA—Illinois Central College
GRAYSLAKE—College of Lake County
MORTON GROVE—Oakton Community College
PALOS HILLS—Moraine Valley Community College

### MEDICAL TECHNOLOGIST

BELLEVILLE—St. Elizabeth Hospital
BLUE ISLAND—St. Francis Hospital
CHAMPAIGN—Burnham City Hospital
CHICAGO—Augustana Hospital & Health Care Center
Grant Hospital of Chicago
Holy Cross Hospital
Illinois Masonic Medical Center
Louis A. Weiss Memorial Hospital
Mercy Hospital & Medical Center
Michael Reese Hospital & Medical Center
Northwestern University Medical School
Rush-Presbyterian-St. Luke's Medical Center
St. Anne's Hospital
St. Anthony Hospital
St. Joseph Hospital
St. Mary of Nazareth Hospital Center
University of Illinois College of Medicine
V. A. Lakeside Hospital
DANVILLE—Lake View Memorial Hospital
DECATUR— Decatur Macon County Hospital
St. Mary's Hospital
EVANSTON—Evanston Hospital
FREEPORT—Freeport Memorial Hospital
GENEVA—Community Hospital
GREAT LAKES—U.S. Naval Regional Medical Center
HINES—V.A. Hospital
HINSDALE—Hinsdale Sanitarium & Hospital
JOLIET—Silver Cross Hospital
St. Joseph Hospital
MAYWOOD—Foster G. McGaw Hosp./Loyola University
NORTH CHICAGO—University of Health Sciences/
Chicago Medical School
OAK LAWN—Christ Community Hospital
OAK PARK—West Suburban Hospital Association
PARK RIDGE—Lutheran General Hospital
PEORIA—Methodist Medical Center of Central Illinois
St. Francis Hospital
QUINCY—St. Mary's Hospital
ROCKFORD—Rockford Memorial Hospital
St. Anthony Hospital
Swedish-American Hospital
SPRINGFIELD—St. John's Hospital
Sangamon State University
URBANA—Carle Foundation Hospital
WAUKEGAN—St. Therese Hospital
WINFIELD—Central DuPage Hospital

### NUCLEAR MEDICINE TECHNOLOGY

CHICAGO—Northwestern Memorial Hospital
St. Mary of Nazareth Hospital Center
EVANSTON—Evanston Hospital
HINES—V. A. Hospital
PARK RIDGE—Lutheran General Hospital
RIVER GROVE—Triton College

### OPERATING ROOM TECHNICIAN

BELLEVILLE—Belleville Area College
CHAMPAIGN—Parkland College
EAST PEORIA—Illinois Central College
MOLINE—Lutheran Hospital
PALOS HILLS—Moraine Valley Community College
QUINCY—Blessing Hospital
RIVER GROVE—Triton College

## OCCUPATIONAL THERAPIST

CHICAGO—University of Illinois College of Medicine

## PHYSICAL THERAPIST

CHICAGO—Northwestern University Medical School
University of Health Science/
Chicago Medical School
University of Illinois College of Medicine

## RADIOLOGIC TECHNOLOGIST

ARLINGTON HTS.—Northwest Community Hospital

BELLEVILLE—Belleville Area College

CENTRALIA—St. Mary's Hospital

CHAMPAIGN—Parkland College

CHICAGO—Central YMCA Community College
Cook County Hospital
DePaul University
Henrotin Hospital
Illinois Masonic Medical Center
Louis A. Weiss Memorial Hospital
Malcolm X Community College
Michael Reese Hospital & Medical Center
Provident Hospital & Training School
Ravenswood Hospital Medical Center
St. Anne's Hospital
St. Joseph Hospital
St. Mary of Nazareth Hospital Center
South Chicago Community Hospital
University of Illinois Hospital
Woodlawn Hospital
Wright Junior College

DANVILLE—Lake View Medical Center

DECATUR—Decatur Macon County Hospital

DIXON—Sauk Valley College

EAST PEORIA—Illinois Central College

ELGIN—St. Joseph Hospital

EVANSTON—St. Francis Hospital

GALESBURG—Carl Sandburg College

GLEN ELLYN—College of DuPage

GRAYSLAKE—College of Lake County

HINSDALE—Hinsdale Sanitarium & Hospital

KANKAKEE—Kankakee Community College

KEWANEE—Kewanee Public Hospital

MACOMB—McDonough District Hospital

MALTA—Kishwaukee College

MOLINE—Lutheran Hospital; Moline Public Hospital

MORTON GROVE—Oakton Community College

NORMAL—Bloomington-Normal School of
Radiologic Technology

OLNEY—Richland Memorial Hospital

PALOS HILLS—Moraine Valley Community College

PEORIA—St. Francis Hospital

QUINCY—Blessing Hospital
St. Mary's Hospital

RIVER GROVE—Triton College

ROCKFORD—Rockford Memorial Hospital
Swedish American Hospital

ROCK ISLAND—Rock Island Franciscan Hospital

SOUTH HOLLAND—Thornton Community College

SPRINGFIELD—Lincoln Land Community College
Memorial Medical Center

## RESPIRATORY THERAPIST

CHAMPAIGN—Parkland College

CHICAGO—Central YMCA Community College
Malcolm X College
Northwestern University affiliated hospitals
University of Chicago Hospitals & Clinics

MOLINE—Lutheran Hospital

PALOS HILLS—Moraine Valley Community College

RIVER GROVE—Triton College

ROCKFORD—St. Anthony Hospital

SPRINGFIELD—Memorial Medical Center

## RESPIRATORY THERAPY TECHNICIAN

CHAMPAIGN—Parkland College

CHICAGO—Northwestern Memorial Hospital
University of Chicago Hospitals and Clinics

MOLINE—Lutheran Hospital

PALOS HILLS—Moraine Valley Community College

QUINCY—St. Mary's Hospital

ROCKFORD—Swedish American Hospital

SPRINGFIELD—St. John's Hospital

WAUKEGAN—Victory Memorial Hospital

## RADIATION THERAPY TECHNICIAN

CHICAGO—Rush-Presbyterian-St. Luke's Medical Center

ELGIN—St. Joseph Hospital

EVANSTON—Evanston Hospital

HINES—V. A. Hospital

MOLINE—Luthern Hospital

ROCKFORD—Swedish American Hospital

## SPECIALIST IN BLOOD BANK TECHNOLOGY

CHICAGO—Mount Sinai Hospital Medical Center
University of Illinois College of Medicine

SPRINGFIELD—St. John's Hospital

PARK RIDGE—Lutheran General Hospital

# ILLINOIS STATE GOVERNMENT

The state government is divided into three branches—legislative, executive and judicial. The legislative power is vested in the General Assembly, which is composed of the State Senate and the House of Representatives (a bicameral assembly).

For representation in the General Assembly, there are 59 Legislative Districts. Each district elects one senator and three representatives. Thus, the Senate has 59 members and the House 177. Under the new constitution, senators are elected for 4 year terms, representatives are elected for 2 year terms.

The General Assembly shall convene each year on the second Wednesday of January. The General Assembly shall be a continuous body during the term for which members of the House of Representatives are elected. The General Assembly's functions are to enact, amend, or repeal laws or adopt appropriation bills, act on amendments to the United States Constitution, and act to remove public officials.

When the House of Representatives is organized, a Speaker or presiding officer is elected for the biennium. The presiding officer of the Senate is the President of the Senate. To facilitate the handling of legislation, the members of the Senate and House are assigned to designated committees to consider bills of like subject matter. These committees usually hold public hearings to discuss legislation before the measure is taken up by the entire House or Senate. There are approximately 50 committees.

## EXECUTIVE BRANCH

The Constitution provides that the Executive Department shall consist of the Governor, Lieutenant Governor, Secretary of State, Comptroller, Treasurer, and Attorney General. These elected officers of the Executive Branch shall hold office for four years, beginning on the second Monday of January after their election and, except in the case of the Lieutenant Governor, until their successors are qualified. They shall be elected at the general election in 1976 and 1978 and every four years thereafter.

## STATE OFFICERS
## 1977

*Governor,* James R. Thompson, Rep., Chicago

*Lieutenant Governor,* Dave O'Neal, Rep., Belleville

*Secretary of State,* Alan J. Dixon, Dem., Belleville

*Comptroller,* Michael J. Bakalis, Dem., Downers Grove

*Treasurer,* Donald R. Smith, Rep., Springfield

*Attorney General,* William J. Scott, Rep., Evanston

*Clerk of the Supreme Court,* Clell L. Woods, Springfield

## LEGISLATIVE BRANCH

### Legislative Procedure

Each member of the General Assembly has the power to introduce bills or resolutions. When a bill is introduced it is read at large a first time, ordered printed, and referred to the proper committee for consideration, except that in case of an emergency, a bill may be advanced without reference to committee. If the committee recommends the bill favorably, it is sent to second reading when amendments to it can be offered for consideration by the entire membership. The bill will then be given a third and final reading after which it is acted upon by the entire membership of the house that is considering it.

### Action by Both Houses

To pass, the bill must receive the favorable vote of the majority of the members elected (89 in the House; 30 in the Senate). These bills are then sent to the other house where essentially the same procedure is followed.

If, because of amendments in the second house, there are two versions of the same bill, conference committees may be appointed to work out the differences. Both houses must vote favorably on the same version of the bill before it can be sent to the Governor for his consideration.

If the Governor thinks the bill should become a law, he will sign it. If the Governor decides it would be unwise for the bill to become law, he can veto it. If he vetoes the bill, he must file a statement of objections. Three-fifths of the members elected to each House can override the veto. He can also veto specific items of an appropriation bill and he may reduce an appropriation. The Governor may also return a bill to the Legislature with specific recommendations for change, thereby obviating the need of vetoing the entire bill.

### *Note*

A Legislative Directory containing the names and addresses of all members of the Illinois General Assembly and the Illinois Senators and Representatives in the Congress is available. Requests should be directed to: Illinois State Medical Society, Regional Office, 701 S. Second St., Springfield 62704.

## DEPARTMENT OF CHILDREN AND FAMILY SERVICES

160 North LaSalle Street, Room 315, Chicago
One North Old State Capitol Plaza, Springfield
Margaret M. Kennedy, *Director*
John Ryan, *Executive Deputy Director*

### Director's Office

Donald H. Schlosser, Director of Staff Services
Lee A. Iverson, Director of Educational and Rehabilitation Services
John Petrilli, Director of Technical Assistance and Monitoring
Peter Digre, Director of Planning, Research and Evaluation
Gary Anderson, Director of Management Services
Paul Freedlund, Administrative Assistant to the Director (Springfield)
Steve Bishop, Administrative Assistant to the Director (Chicago)

## DEPARTMENT OF MENTAL HEALTH AND DEVELOPMENTAL DISABILITIES

401 S. Spring St., Springfield, 62706
160 N. La Salle St., Chicago, 60601
Robert A. deVito, M.D., *Director*
Ivan Pavkovic, M.D., Associate Director
Richard E. Blanton, Ph.D., Associate Director, Developmental Disabilities Services
Noble Emde, Administrator for Management Services
Edwin Goldman, Administrator for Community Services & Interagency Affairs
Roalda Alderman, Superintendent of Alcoholism & Dangerous Drugs Liaison

### Office of the Director

Robert E. Lanier, Special Assistant
Meyer Proctor, Chief, Office of Public Information
Alan E. Grischke, General Counsel
Douglas I. Carey, Legislative Liaison
David B. Thomas, Chief Auditor
Dorothy Ackman, Administrative Assistant
E. Allen Bernardi, Executive Assistant
Bernard W. Jones, Deputy Executive Assistant
Thomas Self, Chief, Systems Design & Evaluation
David Klass, M.D., Research Director
Jack Saporta, Ph.D., Chief, Training & Education
Robert K. Gray

**Director's Executive Council Members and Regional Administrators**

Richard E. Blanton, Ph.D.
Noble Emde
Alan E. Grischke
Douglas I. Carey
Edwin Goldman
Roalda Alderman
John Meyer
Arthur Dykstra
Donald Hart, Region 1A Administrator, Rockford
James Dalzell, Region 1B Administrator, Peoria
Ivan Pavkovic, M.D., Region 2 Acting Administrator, Chicago
Ugo Formigoni, M.D., Region 3A Administrator, Springfield
Dale Kelton, Ph.D., Region 3B Administrator, Decatur
Joseph Gruber, Ph.D., Region 4 Acting Administrator, Alton
Robert C. Steck, M.D., Region 5 Administrator, Anna

### STATUTORY BOARDS AND COUNCILS

**1. Commission on Mental Health and Developmental Disabilities**

Rep. Richard A. Mugalian, Palatine, *Chairman*
Mrs. Judy Buchanan, Bloomington
Hon. John W. Carroll, Park Ridge
Mrs. Carolyn Chapman, Belleville
Sen. Earlean Collins-Grant, Chicago
Sen. Vince Demuzio, Carlinville
Dr. Vernon Frazee, Morton Grove
Mrs. Mary Jeanne Hallstrom, Evanston
Margaret M. Hastings, Ph.D., Kenilworth
Sen. Vivian Veach Hickey, Rockford
Rep. James McPike, Alton
Sen. John J. Nimrod, Glenview
Sen. Frank M. Ozinga, Evergreen Park
Mrs. Rose Poelvoorde, Silvis
Rep. Penny Pullen, Park Ridge
Rep. Jim Reilly, Jacksonville
Hon. Esther Saperstein, Chicago
Rep. Helen Satterthwaite, Champaign
Sen. Jack Schaffer, Cary
Rep. Sam Vinson, Clinton

**2. Psychiatric Advisory Council**

Robert A. deVito, M.D., *Chairman*
Ray Cunningham, M.D., Chicago
Jarl Dyrud, M.D., Chicago
Jan Fawcett, M.D., Chicago
Daniel X. Freedman, M.D., Chicago
Daniel Offer, M.D., Chicago
George H. Pollock, M.D., Chicago
Melvin Prosen, M.D., Chicago
Frank T. Rafferty, M.D., Chicago
Lester H. Rudy, M.D., Chicago
Jackson Smith, M.D., Hines
Michael Taylor, M.D., North Chicago
Terry Travis, M.D., Springfield
Jack Weinberg, M.D., Chicago

## NON-STATUTORY COUNCILS

**1. Citizens' Advisory Council on Alcoholism**

Paul B. Musgrove, Peoria, *Chairman*
Phillip E. Anderson, Danville
Fern Asma, M.D., Chicago
Theodor Bernardy, M.D., Springfield
Robert A. deVito, M.D., Chicago
Ted Eilerman, Granite City
G. W. Grawey, M.D., Peoria
Walter H. Gregg, Ph.D., Evanston
Ms. LaVerne M. Hawes, Chicago
James Jeffers, Chicago
Margaret M. Kennedy, A.C.S.W., Springfield
Julio Cesar Montoya, Chicago
James H. Oughton, Jr., Dwight
William J. Penn, Rockford
Paul Q. Peterson, M.D., Chicago
Arthur F. Quern, Springfield
Maxine Rosenbarger, Ph.D., Carbondale
Charles J. Rowe, Springfield
W. David Steed, M.D., Oak Park
William Thomas, Jr., M.D., Chicago
James West, M.D., Evergreen Park

**2. Citizens' Advisory Council for Community Services**

Philip Carlson, Peoria, *Chairman*
William N. Frayser, Broadview
Ms. Peggy B. Fultz, Highland Park
Ms. Elizabeth Gatlin, Evanston
Helen Hudlin, Ph.D., East St. Louis
Thomas K. Janssen, Nashville
Douglas Jansson, Evanston
Arnold Levin, Ph.D., Chicago
Paul B. Musgrove, Peoria
Robert Norris, Evergreen Park
Samuel A. Patch, Chicago
Hon. James K. Robinson, Danville
Brockman Schumacher, Ph.D., Carbondale
Sister Chaminade Kelley, Springfield

## DANGEROUS DRUGS COMMISSION

The Drug Abuse Offense and Treatment Act of 1972 (PL 92-255) made federal funds available to the states for the purpose of combating drug abuse. In order to receive such funds, a state must submit a plan for implementing and evaluating an effective program for drug abuse prevention, treatment, and rehabilitation. Further, a single state agency must be established as the sole agency for the preparation and administration of the plan and allocation of funds.

The Dangerous Drugs commission also licenses and regulates all drug treatment, education, prevention and rehabilitation programs in the state, except those conducted within a licensed hospital. The Commission sets treatment standards and issues rules and regulations for the operation of drug abuse programs.

Treatment modalities of programs receiving Dangerous Drugs Commission funds include methadone maintenance, both residential and out-patient; drug free residential and out-patient therapy, and hot-line and crisis referral services. In addition to treatment funding, the Dangerous Drugs Commission supports drug counselor training for previously drug dependent clients as well as clinical staff training.

Since reliable and timely data are essential in evaluating the effectiveness of drug abuse treatment and rehabilitation methods, the Information Services Section of the Commission continually collects, analyzes and applies data concerning clinical operations (medical workups, demographics) and regulatory methadone maintenance (counseling, toxicology, prescription dosages.) The Section also keeps a weekly statewide log for methadone clinics, a continuing inventory of drug abuse program resources, and a bank of research data on treatment modalities. All information is strictly confidential.

The Toxicology Division of the Dangerous Drugs Commission is the state laboratory facility which provides drug abuse tests to the state's total client population. The lab is subject to the regulations and standards set by the FDA, the National Institute of Drug Abuse and the Commission itself.

The Dangerous Drugs Commission is located at Marina City Office Building, 300 N. State St., Suite 1500, Chicago, 60610. Phone (312) 822-9860.

Robert A. deVito, M.D., Chicago, *Chairman*
Thomas Kirkpatrick, Jr., *Exec. Director*
Joseph Cronin, Springfield
Patricia D. Craig, R.N., Marion
Stephen Delanty, Palatine
Tyrone Fahner, Springfield
James Jeffers, Chicago
Margaret Kennedy, A.C.S.W., Springfield
Paul Q. Peterson, M.D., Springfield
Arthur Quern, Springfield
Charles Rowe, Springfield
Joseph Skom, M.D., Chicago

**Dangerous Drugs Advisory Council**

Rep. L. Michael Getty, Dolton, *Chairman*
Mrs. Roalda J. Alderman, Chicago
Joan Anderson, Springfield
David Blumenfeld, Esq., Chicago
Murray C. Brown, M.D., Chicago
Emanuel M. Cannonito, Esq., Blue Island
Bernard Carey, Esq., Chicago
Sen. John A. Davidson, Springfield
Hon. John D'Arco, Chicago
Ms. Joan Elbow, Galesburg
David Fox, M.D., Chicago
Norman Garfinkel, Oak Park
Donna Gleespen, Springfield
Chief Charles A. Gruber, Quincy
Rep. George Hudson, Hinsdale
Rep. Tim Johnson, Urbana
Ernest E. LeQuatte, R.Ph., Herrin
Hon. Benjamin S. Mackoff, Chicago
Michael M. Mihm, Esq., Peoria
Richard Moy, M.D., Springfield
Sen. Dawn Clark Netsch, Chicago
Supt. James O'Grady, Chicago
Robert W. O'Leary, Esq., Oak Brook
Ben Palmer, Chicago
Don Paull, Ph.D., Chicago
Sen. James Philip, Downers Grove
David B. Selig, Esq., Wilmette
Harry Sholl, Lake Forest
Jay Ulaneck, Chicago
Rep. Leroy M. VanDuyne, Joliet

# DEPARTMENT OF PUBLIC AID

316 South 2nd St., Springfield
Arthur F. Quern, *Director*

The Illinois Department of Public Aid administers the federally aided public assistance programs: Aid to Families with Dependent Children; Medical Assistance; and provides supplemental financial grants to eligible aged, blind, or disabled persons. In addition, the department allocates state funds to qualified and requesting governmental units for the administration of General Assistance; and in cooperation with the U.S. Department of Agriculture, administers the Food Stamp program.

## Administrative Staff

Lynn D. Carter, Executive Assistant to the Director
David L. Daniel, Assistant Director
H. Dickson Buckley, Special Assistant to the Director (Legislative Liaison)
Jane Snowden, Special Assistant to the Director (Inter-Agency Liaison)
Johnetta W. Jordan, Chief, Office of Public Information
Verne H. Evans, General Counsel, Office of Legal Affairs
Chief Auditor, Vacant
Robert G. Wessel, Chief Assistant to the Director for Field Operations
Norman Ryan, General Services Administrator
Mary Ann Langston, Acting Administrator, Policy & Planning
Jeffrey C. Miller, Medical Assistance Program Administrator
Michael Belletire, Deputy Director, Division of Social Services

### Legislative Advisory Committee on Public Aid

Senator Don A. Moore, Midlothian, *Chairman*
Representative Fred J. Smith, Chicago, *Vice-Chairman*
Senator Richard H. Newhouse, Chicago
Senator Frank M. Ozinga, Evergreen Park
Senator Robert T. Lane, Chicago Heights
Senator Jack Schaffer, Crystal Lake
Representative Charles M. Campbell, Danville
Representative A. C. "Junie" Bartulis, Benld
Representative Emil Jones, Jr., Chicago
Representative Monroe L. Flinn, Cahokia
Representative William L. Kempiners, Joliet
Representative Robert E. Mann, Chicago

### State Medical Advisory Committee

Fred Z. White, M.D., Chillicothe, *Chairman*
Louis Arp, Jr., M.D., Moline
Donald Hoard, M.D., Chicago
F. Paul LaFata, M.D., Springfield, *Consultant*
George T. Mitchell, M.D., Marshall
Robert C. Muehrcke, M.D., Oak Park
Jacob E. Reisch, M.D., Springfield
Fred A. Tworoger, M.D., Chicago
Philip G. Thomsen, M.D., Dolton, *Ex Officio*

# DEPARTMENT OF PUBLIC HEALTH

535 West Jefferson St., Springfield 62706
Paul Q. Peterson, M.D., *Director*

Robert S. Gleason, *Legal Advisor*
Don Vance, *Legislative Liaison*

### Office of Management Services

Associate Director
James H. Thayer
Affirmative Action & Voluntary Resource
Dorothy Friedman
Budget and Fiscal Operation
George Akehurst
Vital Records
Aaron Vangeison
Education and Information
Stan Miles
Electronic Data Processing
Thomas Stuckey
General Services
Joseph Schweska
Management Audit
Walter DeWeese
Implied Consent
Angelo Garella
Public Health Laboratories
Hugh-bert Eberhard, *Chief*

### Office of Health Facilities and Quality of Care

Associate Director
Patricia A. Nolan, M.D.
Division of Administration
Betty J. Williams
Geriatric and Long Term Care Programs
William Irvine
Hospital, Laboratories & Acute Care
Michael Grobsmith
Development and Construction
Aden Clump
Planning and Conformance
Raymond Passeri
Ambulatory Care Review
Leonard A. Kutilek
Curriculum Development
Beth J. Walston
Division of Dental Health
William Babeaux, D.D.S.
Division of Disease Control
Byron J. Francis, M.D.
Poison Control
Karen Gregg
Renal Dialysis
Ruth Shriner
Tuberculosis Control, Lead Poisoning, Occupational Health
Al Grant
Venereal Disease Control
John Meitl
Communicable Disease
Russell Martin, D.V.M.
Division of Family Health, Maternal & Child Care
Patricia Hunt, M.D.
Vision and Hearing
Phil Shattuck

Division of Emergency Medical Services and Highway Safety
Bernard Turnock, M.D.
Hemophilia
Ruth Shriner
Nutrition and Social Services
Pat Fitzgerald

**Office of Health Planning**
Executive Secretary to the SHCC
Roy Armstrong, Jr.
Special Assistant for SHPDA
John A. Napier
Chief, Div. of Planning Coordination
John H. Cotner, Ph.D.
Director, State Center for Health Statistics
Charles Bennett, Ph.D.

**Office of Environmental Health**
Leroy Stratton, Associate Director
Division of Food & Drugs
Roy Upham, D.V.M.
Division of Sanitation
Robert Wheatley
Division of Milk Control
Harold McAvoy
Division of Radiological Health
Maurice Neuweg, *Acting*
Division of Engineering
Jerry Ackerman
Division of Nuclear Safety
Gary Wright

**Office of Health Finance**
Thomas J. Walsh, Ph.D., Associate Director
Division of Hospital Audit
James H. Handy
Division of Research and Development
Thomas J. Walsh, Ph.D.

**Public Health Laboratories**
2121 West Taylor, Chicago, 60612
134 North 9th Street, Springfield 62706
P.O. Box 2467, Carbondale 62901

## STATUTORY BOARDS AND COMMISSIONS
## (Allied with Public Health Operations)

**Long-Term Care Facility Advisory Board**
Marian L. Ascoli, Urbana
Glenda Ashley, M.D., Chicago
Louis Brackett, Orland Park
Michael N. Fleming, R.N., Franklin Grove
Mary Gibb, Evanston
Robert Johnson, M.D., Springfield
C. F. Kerchner, Fairfield
Herbert M. Krauss, Evanston
Peter Mule, Mundelein
Catherine L. Roe, Cuba
Allan Roney, Springfield
Marie Sadlick, LaGrange Park
Leon Shlofrock, Chicago
Ray Unterbrink, Springfield
June Yeske, Bloomington
Tom Toberman, Springfield, *ex-officio*
Robert Lanier, Springfield, *ex-officio*
Leroy Cohnen, Springfield, *ex-officio*
Patricia A. Nolan, M.D., Chairperson *ex-officio*

**Drivers License Medical Advisory Board**
Robert Bettasso, M.D., Ottawa
General Surgeon
Joel Kaplan, M.D., Chicago
Ophthalmologist
James F. Kurtz, M.D., LaGrange
Orthopedic Surgeon
Frank Norbury, M.D., Jacksonville
Internist
Ronald P. Pawl, M.D., Chicago
Neurological Surgery
Paul Schmidt, M.D., Galva
Family Physician
Ronald Shlensky, M.D., Chicago
Psychiatrist
Alan J. Stutz, M.D., Springfield
Therapeutic Radiologist

**Hazardous Substances Advisory Council**
Richard C. Reinke, Lemont
Edward F. O'Toole, Chicago
Ken Cole, Chicago
Mrs. Jiffy Johnson, Springfield

**Ambulatory Surgical Treatment Center Licensing Board**
Edward A. Brunner, M.D., Skokie
Dorothy L. Caballero, R.N., Chicago
Jon M. Dosher, Havana
Edward D. Gehres, Jr., Decatur
Donald W. Hugar, D.P.M., River Forest
Edward J. Jacobs, M.D., Arlington Heights
Donald Jerome, M.D., Belleville
Irwin N. Lebow, D.D.S., Normal
William D. McNobola, M.D., Wilmette
Peggy Montes, Chicago
Caryl Towsley Moy, Springfield
Ruth Surgal, Chicago

**Clinical Laboratory and Blood Bank Advisory Board**
Grant C. Johnson, M.D., Springfield, *Chairman*
Thiru Viathanathan, M.D., Skokie
Wayne N. Leimbach, M.D., Aurora
Mrs. Dorothea M. Prevo, M.S., Glencoe
Hugh J. McDonald, Sc.D., Skokie

**Hospital Licensing Board**
Elmer E. Abrahamson, Chicago
Sister Ann Bailey, Springfield
Theodor L. Jacobsen, Park Ridge
Thos. R. Jones, Peoria
Robert E. Lanier, Springfield
William M. Lees, M.D., Lincolnwood
Earl D. Long, D.C., Marion
M. Frances Nash Terrell, East St. Louis
Robert H. Reeder, M.D., Geneva
June Werner, R.N., Evanston
Marshall Witzel, Wilmette

**Radiation Protection Advisory Council**
Larry Lanzl, Ph.D., Chicago, *Chairman*
Howard Burkhead, M.D., Evanston
Jerome J. Steerman, Urbana
Seymour Yale, D.D.S., Chicago
F. E. Demaree, Chicago
John Rust, D.V.M., Chicago
Lawrence Levin
Director of Labor, *ex-officio*
Chairman, Commerce Commission, *ex-officio*

**Illinois Chronic Renal Disease Advisory Committee**
Paul Q. Peterson, M.D., Springfield, *Chairman*
Arthur F. Abney, Chicago
Edmund J. Lewis, M.D., Chicago
David P. Earle, M.D., Chicago, *Consultant*
Alan Kanter, M.D., Chicago
Robert M. Kark, M.D., Chicago, *Consultant*
Robert H. Pflederer, M.D., Peoria
Franklin D. Schwartz, M.D., Chicago
Francisco DelGreco, M.D., Chicago
George Dunea, M.D., Chicago
Glen Anderson, Chicago
Alan G. Birtch, M.D., Springfield
Olga Jonasson, M.D., Chicago
Dean Stanley, Chicago
Ewald T. Sorenson, M.D., Rockford
Harold Schwartz, Lincolnwood
Richard Bilinsky, M.D., Springfield

**Immunization Advisory Committee**
Mark Lepper, M.D., Hinsdale, *Chairman*
John B. Hall, M.D. Chicago
Joseph R. Kraft, M.D., Chicago
David Greeley, M.D., Chicago
Byron J. Francis, M.D., Springfield, *Technical Secretary*
James P. Paulissen, M.D., Wheaton
Daniel J. Pachman, M.D., Chicago
Loren Boon, M.D., Danvers
Patricia A. Hunt, M.D., Springfield, *Staff*

**Health Facilities Planning Board**
Jack T. Knuepfer, Elmhurst, *Chairman*
Cornelia West Foley, Rockford
Nancy B. Jefferson, Chicago
Robert Petersen, Wheaton
Mabry Roby, Chicago
Andrea R. Rozran, Chicago
Mildred Louise Sammons, East St. Louis
Jean A. Smith, Manteno
John M. Stagl, Glenview
John F. Wayland, LaSalle
Martin Koldyke, Kenilworth
Edward Newman, M.D., Chicago
Paul Q. Peterson, M.D., Chicago, *ex-officio*
Robert deVito, M.D., Chicago, *ex-officio*
Arthur F. Quern, Springfield, *ex-officio*

**Tuberculosis Advisory Committee**
Ben Kiningham, Springfield
Eric Peterson, M.D., Coal Valley
Mrs. Esther Smith, Chicago
Virgil Smith, Metropolis
H. H. Rohrer, M.D., Peoria
Whitney Addington, M.D., Chicago
John C. Rogers, Glen Ellyn
John Weisnar, Cairo

**Advisory Board of Necropsy Service to Coroners**
Thomas H. Hanlon, Arlington Heights
Welland Hause, M.D., Decatur
Ronald Kowalski, M.D., Peoria
Richard H. Lynch, Charleston
Rae Rairdin, Arlington Heights
Norman T. Richter, Springfield
Grover L. Seitzinger, M.D., Danville
Robert Smith, Jerseyville
Robert K. Matthews, Chicago

**Statewide Health Coordinating Council**
Alice Adler, Wilmette
Barbara Anderson, Coal Valley
Salley D. Berger, Chicago
Lloyd M. Bertholf, Ph.D., Bloomington
Timuel D. Black, Chicago
Paul R. Booth, Chicago
Curtis K. Brady, Bourbonnais
John L. Carothers, Chicago
Julia R. Cihak, R.N., Springfield
Kenneth W. Cote, Kankakee
Nicholas Cotsonas, M.D., Peoria
Doris Dalton, Joliet
Maria Diaz, Chicago
Ted Eilerman, Granite City
John E. Ekblad, Rock Island
Wilbert Exline, Moline
Ruth Eyre, Leaf River
Shirley Flaherty, Elmhurst
Victoria Gibson, East St. Louis
Edward Glover, D.C., Peoria
Eugenia Handler, Carbondale
Joseph Heimann, Germantown
Henrietta Herbolsheimer, M.D., Chicago
Michael S. Holewinski, Chicago
B. Smith Hopkins, M.D., Urbana
William Kabisch, Ph.D., Springfield
Sara Kessler, Decatur
Judy King, DeKalb
Mark H. Lepper, M.D., Hinsdale
Charles Lipe, Springfield
Sharon Mallek, Chicago
Cleveland Matthews, Carbondale
Chester Nosal, Chicago
Marilyn Notkin, Chicago
Edward Palmer, Chicago
James E. Peeples, Peoria
Esta Pekow, Highland Park
Edward Perry, O.D., Salem
Marjorie Quandt, North Chicago
Robert Quisenberry, Emden
Hugh Rohrer, M.D., Peoria
J. Allan Roney, Springfield
Lois A. Rosen, Chicago
Sally Safelis, Freeport
Douglas Spencer, Springfield
Edward Starr, Oak Park
Margaret Summers, New Berlin
John A. Taft, Jr., St. Charles
John D. Thorpe, D.D.S., LaGrange
John F. Wayland, LaSalle
Mollie L. West, Chicago
Kenneth Wilson, Springfield
Robert O. Wright, Peoria

**Prevention of Accidental Poisoning in Children Advisory Committee**
Byron J. Francis, M.D., M.P.H., Springfield
J. Keller Mack, M.D., Springfield
W. L. Crawford, M.D., Rockford
Paul Pierce, M.D., Alton
Walter M. Whitaker, M.D., Quincy
Joseph R. Christian, M.D., Chicago
John B. Stull, M.D., Olney

**Illinois Health Facilities Authority**
Benjamin Wolfe, Chicago, *Executive Director*
Stanford Glass, Winnetka, *Chairman*
Roger D. Herrin, D.P.M., Harrisburg, *Vice-Chairman*
Charles E. Hayes, Arlington Heights
Louis G. Alexander, Chicago
Irene Mills, Decatur
Tim Miller, Peoria
Robert Kane, M.D., Herrin

**HMO Advisory Council**

Dean Bordeaux, M.D., Peoria, *Acting Chairman*
Sister Marta Goski, Edwardsville
Henry Kutsch, Chicago
Roger Murray, R.Ph., Chicago
E. L. Palmer, Chicago
Lyn C. Sinclair, R.N., Evanston
Warren F. Spencer, M.D., Evanston
Victor Trautmann, M.D., Springfield

**Alcoholism Treatment Licensure Program Advisory Board**

Patrick Cullinane, Carbondale, *Chairman*
Gene Crooks, Champaign
Lee Gladstone, M.D., Chicago
Ben Loudermilk, Jacksonville
Robert Downs, Oak Park
Betty Strickland, Park Ridge
Patricia A. Nolan, M.D., *Chairperson, ex-officio*
Roalda J. Alderman, *ex-officio*
Dept. of Mental Health and Developmental Disabilities

**Mobile Intensive Care Advisory Board, *P.A. 78-1271***

Joseph D. Winterhalter, M.D., Jacksonville, *Chairman*
Terrence S. Carden, M.D., Highland Park, *Vice-Chairman*
Eugene Cowsert, Wood River
John Holland, M.D., Springfield
Kathy LaGreca, R.N., McHenry
Barbara Lyons, R.N., Waukegan
Paul Mesnick, M.D., Chicago
Chief Robert Murray, Bridgeview
Louis A. Reibling, Ph.D., Belleville
Susan Weed, Chicago

**Drug Substitution Program Technical Advisory Council, *P.A., 80-976***

Raymond J. Cicci, R.Ph., Springfield
Vincent A. Costanzo, R.Ph., M.D., Chicago
Donald R. Gronewold, R.Ph., Washington
Dorothy H. Hubler, R.Ph., M.D., Casey
August P. Lemberger, R.Ph., Ph.D., Chicago
James T. O'Donnell, R.Ph., Pharm.D., Chicago
Richard H. Suhs, M.D., Springfield

**Hemophilia Advisory Committee, *P.A. 80-859***

Marilyn Hruby, M.D., Chicago
Naidene Kirwan, Oak Lawn
Donald E. Ore, D.D.S., Chicago Heights
William Rushakoff, Chicago
Dean Stanley, Chicago
Margaret Telfer, M.D., Chicago
Robert M. Terzich, Springfield
Gwendolyn White, M.D., Springfield

**Rape Advisory Board, *P.A. 79-564***

Larry S. Boress, Chicago
Jane Fay, R.N., DeKalb
Penny Finn, Springfield
Herb Gardner, Oak Brook
Michael Grobsmith, Springfield
Karen Hickman, Chicago
Karen Kabat, R.N., Springfield
Max Klinghoffer, M.D., Elmhurst
Allen N. Koplin, M.D., M.P.H., Springfield
Goldie Lansky, Chicago
Nancy Mermelstein, Springfield
Miriam Moore, R.N., B.S.N., Chicago
Judy Mostovoy, Park Forest
Roger Quick, Springfield
Joseph Rossi, Jr., Chicago
Fred Schlosser, Jr., Springfield
Francine Stein, Skokie
Joseph D. Winterhalter, M.D., Jacksonville

**Advisory Committee for Family Practice Residency Act, *HB 106, 107; P.A. 84-78, 84-79***

Roy W. Armstrong, Jr., Chicago
Mrs. John D. Baldwin, Chicago
John M. Holland, M.D., Springfield
Martin E. Levitt, D.O., Chicago
Richard H. Moy, M.D., Springfield
Jorge Prieto, M.D., Chicago
Genevieve Alloy Watson, Peoria
Norman F. Webb, Chicago
Fred Z. White, M.D., Chillicothe

**Advisory Hospital Council**
*Public Agencies*
Robert E. Lanier, Springfield
Robert G. Wessel, Springfield

*Providers*
Murray Berg, Chicago
Francis Bihss, M.D., Belleville
Daniel K. Bloomfield, M.D., Urbana
David S. Forkosh, M.D., Chicago
Andrew J. Griffin, M.D., Chicago
Fredric D. Lake, M.D., Evanston
Robert M. Magnuson, Elmhurst
John W. Rice, Chicago
James P. Streitz, Danville

*Consumers*
Larry Bullock, Chicago
Margaret Cassin, East St. Louis
Louise M. Eggert, Oak Lawn
Hilda E. Frontany, Chicago
Vera Fina, Riverside
Susan B. Gende, Moline
Georgia Gleason, Marselles
Nancy B. Jefferson, Chicago
Lee Pravatiner, Chicago
Geoffrey H. Raymond, Oak Park

## NON-STATUTORY BOARDS

### (Allied with Public Health Operations)

**Committee for Revision of the Rules and Regulations for the Control of Communicable Diseases**

Byron J. Francis, M.D., M.P.H., Springfield, *Chairman*
John B. Hall, M.D., M.P.H., Chicago
Olga Brolnitsky, M.D., Chicago
Hugh Rohrer, M.D., Peoria
Stuart Levin, M.D., Chicago
Daniel J. Pachman, M.D., Chicago, *ex-officio*
Hugh-Bert Everhard, Chicago
Patricia Hunt, M.D., Springfield

**Advisory Committee for PKU and Other Genetically Related Diseases**

Patricia Hunt, M.D., Springfield, *Chairman*
Julian Bierman, M.D., Chicago
John B. Hall, M.D., M.P.H., Chicago
Edward F. Lis, M.D., Springfield
Reuben Matalon, M.D., Chicago
Margaret E. O'Flynn, M.D., Chicago
Daniel J. Pachman, M.D., Chicago
Julio Pardo, M.D., Springfield
Eugene Pergament, M.D., Ph.D., Chicago
Ira M. Rosenthal, M.D., Chicago
Parvin Justice, Ph.D., Chicago
A. R. Sharp., M.D., St. Louis
Paul Wong, M.D., Chicago
Hugh-Bert Everhard, Chicago
Robert T. Martinek, Ph.D., Chicago
Mindy Pollack, Chicago

**Perinatal Advisory Committee**

Silvio Aladjem, M.D., Chicago, *Chairman*
Gail Wilson, Chicago
John Taft, St. Charles
John J. Boehm, M.D., Chicago
Patricia Nolan, M.D., Springfield
John Madden, M.D., Chicago
Kofi Amankwah, M.D., Springfield
Tim Miller, M.D., Peoria
Gerald Staub, M.D., Rockford
William Ott, M.D., St. Louis
Richard Marshall, M.D., St. Louis
Rosita Pildes, M.D., Chicago
Merrill W. Huffman, M.D., Urbana
John R. Powell, M.D., Urbana
William Hamilton, M.D., Carbondale
Peter Pleotis, M.D., Arlington Heights
George Dohrmann, M.D., Chicago
John Holland, M.D., Springfield
Gail Scyoc, Alton
Lillian Runnerstrom, Ph.D., C.N.M., Chicago
Ben Robbins, M.D., Urbana
Edward Lis, M.D., Springfield
Donald Sherline, M.D., Chicago
Richard M. Nachman, M.D., Chicago
Helen Simmons, Chicago
Joseph Orthoefer, D.V.M., Rockford
William Gottschalk, M.D., Chicago

**Advisory Committee on Pediatric Lead Poisoning**

Fred Z. White, M.D., Chillicothe, *Chairman*
A. J. Kiessel, M.D., Decatur, *Vice-Chairman*
Ira M. Rosenthal, M.D., Chicago
Guy A. Pandola, M.D., Joliet
Eleanor Berman, Ph.D., Chicago
Henrietta K. Sachs, M.D., Glencoe
Ronald B. Mack, M.D., Berwyn
Rowine Hayes-Brown, M.D., Chicago
Byron J. Francis, M.D., Springfield
Leroy Stratton, Springfield
Paul Q. Peterson, M.D., Springfield, *Ex-Officio*

**Hypertension Advisory Committee**

Eli L. Borkon, M.D., Carbondale, *Chairman*
Richard Bilinsky, M.D., Springfield
Richard Christansen, M.D., Rockford
Elizabeth Lynch, Springfield
Ray Restivo, Chicago
David M. Berkson, M.D., Chicago
James Schoenberger, M.D., Chicago
Jeremiah Stamler, M.D., Chicago
Ella M. Lacey, Carbondale
George Dunea, M.D., Chicago

**Advisory Committee for the Child Hearing Test Act**

James R. Nelson, Springfield, *Exec. Sec.*
Charles Pfotenhauer, Springfield
Lloyd Mosley, Springfield
John B. Hall, M.D., Chicago
Kenneth Mangan, Ed.D., Jacksonville
Ralph Naunton, M.D., Chicago
William Plotkin, Ph.D., Chicago
Paul Rittmanic, Ph.D., Dixon
Robert K. Simpson, Ph.D., Champaign
Ann Russell, Chicago
George Skertich, South Holland
Bill K. Tilley, Ph.D., Springfield
William P. Johnson, Ph.D., Jacksonville
Penny Meyers, Skokie

## POISON CONTROL CENTERS IN ILLINOIS

For information contact:
Division of Emergency Medical Services & Highway Safety
Illinois Department of Public Health
525 W. Jefferson
Springfield, 62761
Phone: (217) 782-5278

## APPROVED RENAL DIALYSIS FACILITIES, CENTERS AND DIRECTORS

Illinois Department of Public Health
Division of Disease Control

*For information contact:*

Mrs. Ruth S. Shriner, ACSW—Coordinator Direct Services
Programs, Illinois Department of Public Health,
Room 150, 535 West Jefferson Street, Springfield 62706
Phone (217) 782-3303

## DEPARTMENT OF REGISTRATION AND EDUCATION

628 East Adams Street, Springfiield
55 East Jackson Boulevard, Chicago

Joan G. Anderson, *Director*
Thomas Ortciger, *Assistant Director*
Jerry D. Sternstein, *Deputy Director-Licensing*
Jacob M. Shapiro, *Chief Counsel*
Algis Augustine, *Chief Regulatory Officer*

The department is primarily concerned with the registration, licensing and enforcement of 30 laws governing the different professions, trades and occupations, including the Medical Practice Act.

The Medical Examining Committee appointed by the director of the department operates within the framework of the act and is charged with the responsibility of supervising examinations for licensure and making recommendations to the Director to grant or refuse to grant licenses. The Medical Disciplinary Board hears complaints for revocation and suspension of licenses and recommends disciplinary action to the Director.

### Medical Examining Committee

Richard Rovner, M.D., Chicago, *Chairperson*
Mays Maxwell, M.D., East St. Louis, *Vice-chairperson*
Paul Tullio, D.C., Glen Ellyn, *Secretary*
Charles Bobelis, M.D., Dundee
David Fox, M.D., Chicago
Robert Behmer, M.D., Rockford

### Medical Disciplinary Board

Willard C. Scrivner, M.D., Belleville, *Chairperson*
George Caleel, D.O., Chicago, *Vice-chairperson*
Sam Brinkley, D.C., Alton, *Secretary*
Helen C. Bonbrest, M.D., Chicago
Levon Krikor Topouzian, M.D., Skokie
James B. Williams, M.D., Chicago
Raimundo Rodriguez, M.D., Murphysboro

## MEDICAL PRACTICE ACT

*Service on medical committees—Exemption from civil liability.* § 2b. While serving upon any Medical Utilization Committee, Medical Review Committee, Patient Care Audit Committee, Medical Care Evaluation Committee, Quality Review Committee, Credential Committee, Peer Review Committee or any other committee whose purpose, directly or indirectly, is internal quality control or medical study to reduce morbidity or mortality, or for improving patient care within a hospital duly licensed under the Hospital Licensing Act, or the improving or benefiting of patient care and treatment whether within a hospital or not, or for the purpose of professional discipline, any person serving on such committee, and any person providing service to such committees shall not be liable for civil damages as a result of his acts, omissions, decisions, or any other conduct in connection with his duties on such committees, except those involving willful or wanton misconduct. *Amended by P.A. 79-1434 § 7, eff. Sept. 19, 1976; P.A. 80-771, § 3, eff. Oct. 1, 1977.*

*Practice by person licensed in another state pending examination.* § 2c.

This act does not prohibit the practice of medicine by a person who is licensed to practice medicine in all of its branches in any other state of the United States or the District of Columbia who has applied in writing to the Department, in form and substance satisfactory to the Department, for a license to practice medicine in all of its branches and has complied with all of the provisions of Section 13, except the passing of an examination which may be given under Section 13, until:

(a) the expiration of 6 months after the filing of such written application, or

(b) the decision of the Department that the applicant has failed to pass an examination within 6 months or failed without an approved excuse to take an examination conducted within 6 months by the Department, or

(c) the withdrawal of the application. (Added by Act approved July 26, 1971)

*Dispensing drugs or medicine—Label.*] § 2d. Any person licensed under this Act who dispenses any drug or medicine shall affix to the box, bottle, vessel or package containing the same a label indicating (a) the date on which such drug or medicine is dispensed; (b) the last name of the person dispensing such drug or medicine; (c) the directions for use thereof; and (d) the proprietary name or names or, if there is none, the established name or names of the drug or medicine, the dosage and quantity, unless the person dispensing the drug or medicine determines that the health of the person to whom the drug or medicine is dispensed requires that such information be omitted. This Section shall not apply to drugs or medicines in a package which bears a label of the manufacturer containing information describing its contents which is in compliance with requirements of the Federal Food, Drug and Cosmetic Act and the Illinois Food, Drug and Cosmetic Act and which is dispensed without consideration by a practitioner licensed under this Act. "Drug" and "medicine" have the meaning ascribed to them in the "Pharmacy Practice Act," approved July 11, 1955, as now or hereafter amended. *Formerly § 2c. Renumbered § 2d by P.A. 77-1849, § 3, eff. July 1, 1972.*

§ *2d5. Minimum standards of professional education.* Except as provided in Section 9a of this Act, the minimum standards of professional education to be enforced by the department in conducting examinations and issuing licenses shall be as follows:

1. *Practice of Medicine.* For the practice of medicine in all of its branches:

(a) For an applicant who is a graduate of a medical college before the passage of this Act, that such medical college at the time of his graduation required as a prerequisite to graduation a 4 years' course of instruction of not less than 9 months each, in such medical college, or its equivalent, the time elapsing between the beginning of the first year and the ending of the fourth year having been not less than 40 months, and which was reputable and in good standing in the judgment of the department; and prior to taking such examination said applicant must present proof that he has completed a 4 years' course of instruction in a high school or its equivalent as determined by an examination conducted by the department.

(b) For an applicant who is a graduate of a medical college after the passage of this Act, that such medical college at the time of his graduation required as a prerequisite to admission thereto 2 years' course of instruction in a college of liberal arts, or its equivalent, or in such medical college, and a course of instruction in a medical college in the treatment of human ailments, which course shall have been not less than 132 weeks in duration and shall have been completed within a period of not less than 35 months, and in addition thereto, a course of clinical training of not less than 12 months in a hospital, such college of liberal arts, medical college and hospital having been reputable and in good standing in the judgment of the department. The time requirement of not less than 132 weeks within a period of 35 months, set forth above, may be reduced by the department upon recommendation of the Dean of the medical school in the case of programs involving students with advanced standing.

(c) For an applicant who is a graduate of a medical college or school in another country; that such applicant was a resident of this State for a period of five years prior to matriculating in such medical college or school; that such applicant completed a required course of instruction in the treatment of human aliments as offered by such college or school of medicine, which course shall have been not less than 132 weeks in duration and shall have been completed within a period of not less than 35 months; that such applicant has completed a minimum of three years' course of instruction in an accredited college of liberal arts or its equivalent; that such applicant submit an application to an Illinois medical school and submit to such testing procedures, including use of nationally recognized medical student tests and/or tests devised by the individual medical school, to determine equivalency of education compared to state norms, such testing could be utilized in placement of such applicant at a level appropriate to educational achievement; that such applicant may be placed by an Illinois medical school into the appropriate level of medical school, thru internship training, provided that applicant agrees to pay, either by a scholarship or some other personal means, such tuition and fees necessary to complete medical education, and provided that such applicant signs a statement in a form to be determined by the Department that upon successful completion of all licensure requirements applicant intends to practice medicine in this State. Upon completion of such course or activity of didactic and medical training as specified by an accepting medical school, applicant shall be eligible for award of an M.D. degree and examination and licensing for the practice of medicine in all of its branches as provided in this act and upon payment of the fee provided in paragraph (a) of sub-section 4 of Section 4 of this Act.

(d) Until September 1, 1988, for an applicant who has studied medicine at a medical college or school located outside the United States; that such applicant has completed all of the formal requirements of a foreign medical school except internship and/or social service, which course shall have been not less than 132 weeks in duration and shall have been completed within a period of not less than 35 months; that such applicant has completed a minimum of 3 years' course of instruction in an accredited college of liberal arts or its equivalent; that such an applicant has submitted an application to a medical school recognized by the Department and submitted to such evaluation procedures, including use of nationally recognized medical student tests and/or tests devised by the individual medical school and that such applicant has satisfactorily completed one academic year of supervised clinical training under the direction of such medical school; and, after completion of said academic year of supervised clinical training, that such applicant has satisfactorily completed twelve months of post graduate training in an approved hospital having been reputable and in good standing in the judgment of the Department; and provided that such applicant sign a statement and a form, to be determined by the Department, that upon successful completion of all license requirements, applicant intends to practice medicine in this state. Upon completion of such course or activity of didactic and medical training as specified by an accepting medical school,

applicants shall be eligible for examination and licensing for the practice of medicine in all of its branches as provided in this Act and upon payment of the fee provided in paragraph (a) of sub-section 4 of Section 4 of this Act.

Until September 1, 1988, satisfaction of the requirements of this sub-section shall be in lieu of the completion of any foreign internship and/or social service requirements, and no such requirements shall be a condition of licensure as a physician in this State.

Until September 1, 1988, satisfaction of the requirements of this sub-section shall be in lieu of certification by the Educational Council for Foreign Medical Graduates, and such certification shall not be a condition of licensure as a physician in this State for candidates who have completed the requirements of this sub-section.

Until September 1, 1988, no hospital licensed by the State, or operated by the State or political subdivision thereof, or which receive State financial assistance, directly or indirectly, shall require an individual who at the time of his enrollment in a medical school outside the United States is a citizen of the United States, to satisfy any requirement other than those contained in this sub-section prior to commencing an internship or residency.

Until September 1, 1988, a document granted by a medical school located outside the United States which certifies completion of all of the formal training requirements of such foreign medical school except internship and/or social service; and satisfactory completion of the examination and academic year of supervised clinical training at a medical school recognized by the Department referred to in this sub-section shall be deemed the equivalent of the degree of Doctor of Medicine for purposes of licensure and practice as a physician in this State and shall possess all the rights and privileges thereof.

The Illinois Board of Higher Education may make grants to Illinois Medical Schools, public and private, for each applicant who commences his academic year of supervised clinical training under the direction of said medical school. Preference shall be given in the award of these grants to Illinois residents. The Illinois Board of Higher Education shall by regulation adopt reasonable guidelines for the distribution of funds authorized by this Act. (Added by Act approved Sept. 7, 1974).

2. *Treating human ailments without drugs or medicines and without operative surgery.* For the practice of any system or method of treating human ailments without the use of drugs or medicines and without operative surgery:

(a) For an applicant who was a resident student and who is a graduate before July 1, 1926, of a professional school, college or institution which taught the system or method of treating human ailments, which he specifically designated in his application as the one he would undertake to practice, that such school, college or institution at the time of his graduation required as a prerequisite to graduation a 3 years' course of instruction of not less than 6 months each, the time elapsing between the beginning of the first year and the ending of the third year having been not less than 22 months, and which are reputable and in good standing in the judgment of the department and prior to taking the examination the applicant must present proof that he has completed a 4 years' course of instruction in high school, or its equivalent, as determined by an examination conducted by the department.

(b) For an applicant who was a resident student and who is a graduate after July 1, 1926, of a professional school, college or institution which taught the system or method of treating human ailments which he specifically designated in his application as the one which he would undertake to practice, that such school, college or institution at the time of his graduation required as a prerequisite to admission thereto a 4 years' course of instruction in a high school, and as a prerequisite to graduation therefrom a course of instruction in the treatment of human ailments, of not less than 132 weeks in duration and shall have been completed within a period of not less than 35 months except that as to students matriculating or entering upon a course of study of any system or method of treating human ailments without the use of drugs or medicines and without operative surgery during the years 1940, 1941, 1942, 1943, 1944, 1945, 1946 and 1947, the said elapsed time shall be not less than 32 months, such high school and such school, college, institution having been reputable and in good standing in the judgment of the department.

(c) For an applicant who is a matriculant in a chiropractic college after September 1, 1969, that such applicant shall be required as a prerequisite for admission to examine for licensure, to complete a 2 years' course of instruction in a liberal arts college or its equivalent, and a course of instruction in a chiropractic college in the treatment of human ailments, such course as a prerequisite to graduation therefrom having been not less than 132 weeks in duration and shall have been completed within a period of not less than 35 months, such college of liberal arts and chiropractic college having been reputable and in good standing in the judgment of the Department.

3. *Midwifery.* For the practice of midwifery: That he be a graduate of a college of midwifery which requires as a prerequisite to admission thereto, a one year's course of instruction in a high school or its equivalent, and required as a prerequisite to graduation, a one year's course in such college of midwifery, the time actually spent under instruction in such college of midwifery to have been not less than 12 months; such high school or equivalent school, and such college of midwifery having been in good standing in the judgment of the department.

Without prejudice to licenses heretofore issued under this section, no further licenses shall be issued under this section after the effective date of this amendment. Amended by P.A. 80-368. § 1, eff. Oct. 1, 1977.

## Continuing Education

Continuing education—Recommendations by Examining Committee]

The Department, based on the written recommendation of the Examining Committee, shall promulgate mandatory requirements of continuing education for persons licensed pursuant to this Act. In establishing such recommendations, the Committee shall:

(1) Develop practical and meaningful criteria for defining and describing continuing education

requirements which meet, but are not limited to, the following specifications:

(a) Readily available to all practicing physicians in Illinois without undue commitment of time away from practice and expense on the part of the practitioner.

(b) Compatible with existing requirements of licensing agencies in other states.

(c) Compatible with the requirements of medical specialty boards for recertification of specialty status.

(d) Compatible with the continuing education requirements developed by national medical specialty societies.

(e) Compatible with continuing education programs and requirements that are developed in federally mandated peer review programs and as a part of Professional Standards Review Organizations.

(f) Provides for differing requirements for licensees engaged in other than direct patient care (example: educators, researchers and those engaged in medical administration).

(g) Provides for compatible requirements for licensees in the federal uniformed services, those engaged in formal residency and fellowship training programs, and licensees operating under hospital permit licensure.

(2) Conceive, develop and evaluate procedures, materials and systems to carry out the administrative requirements of this legislation which include, but are not limited to, the following:

(a) Procedures for prompt and fair evaluation of reports of educational achievement submitted by licensees.

(b) Requirements and position descriptions for personnel engaged in reviewing and evaluating reports and continuing educational achievements submitted by licensees.

(c) A data recording system for gathering, analyzing, storing and retrieving information on individual licensee educational accomplishments.

(d) Provision for licensee to appeal adverse actions and temporary exemptions from requirements under unusual circumstances.

(e) Exemption from legal prosecution of all persons responsible for action taken under the program.

(f) Establishment of realistic budgeting and cost requirements for the personnel, and operational funds necessary to plan, develop and operate the program.

(g) Procedures for surveying and evaluating the effectiveness of the program.

(h) Orderly procedures for adequate notice to licensee of pending action that may result in non-renewal of license, including provisions for consultation and assistance in time for him to meet the requirements of this Act.

(3) Develop adequate protection for information about licensee participation in continuing education as it pertains to all aspects of practice liability and the licensee's public image and his relationships with individual patients.

(4) Develop an advisory panel for each category of licensee to advise and assist the department in development and application of continuing education criteria, administrative procedures and policy.

(5) Develop procedures for assuring that the educational opportunities available to licensees for fulfilling the requirements of this act are of appropriate scope, variety, depth and of high quality.

The Department shall enforce these requirements; however, the Department shall be empowered to waive enforcement of these requirements in localities where it is demonstrated that the absence of opportunities for such education would interfere with the adequacy of medical services in that locality. Added by P.A. 79-1136, §1, eff. July 1, 1976.

## Revocation and Suspension of License or Certificate

*Revocation and suspension of license or certificate—Grounds—Limitation—Insanity—Resumption of practice on restoration.*]

The Department may revoke, suspend, place on probationary status, or take any other disciplinary action as the Department may deem proper with regard to the license, certificate or state hospital permit of any person issued under this Act or under any other Act in this State to practice medicine, to practice the treatment of human ailments in any manner or to practice midwifery, or may refuse to grant a license, certificate or state hospital permit under this Act or may grant a license, certificate or State hospital permit on a probationary status subject to the limitations of the probation, and may cause any license or certificate which has been the subject of formal disciplinary procedure to be marked accordingly on the records of any county clerk upon the following grounds:

1. Performance of an elective abortion in any place, locale, facility, or institution other than:
   (a) a facility licensed pursuant to the "Ambulatory Surgical Treatment Center Act" as heretofore or hereafter amended;
   (b) an institution licensed pursuant to "An Act relating to the inspection, supervision, licensing and regulation of hospitals," approved July 1, 1953, as heretofore or hereafter amended; or
   (c) an ambulatory surgical treatment center or hospitalization care facility maintained by the State or any agency thereof, where such department or agency has authority under law to establish and enforce standards for the ambulatory surgical treatment centers, hospitalization, or care facilities under its management and control, or
   (d) ambulatory surgical treatment centers, hospitalization or care facilities maintained by the Federal Government; or
   (e) ambulatory surgical treatment centers, hospitalization or care facilities maintained by any university or college established under the laws of this State and supported principally by public funds raised by taxation;

2. Conviction in this or another state of any crime which is a felony under the laws of this State or conviction of a felony in a federal court, unless such person demonstrates

to the Department that he has been sufficiently rehabilitated to warrant the public trust;

3. Gross or repeated malpractice resulting in serious injury or death of a patient;
4. Engaging in dishonorable, unethical or unprofessional conduct of a character likely to deceive, defraud, or harm the public;
5. Obtaining a fee, either directly or indirectly, either in money or in the form of anything else of value or in the form of financial profit as personal compensation, or as compensation, charge, profit or gain for an employer or for any other person or persons, on the fraudulent representation that a manifestly incurable condition of sickness, disease or injury or any person can be permanently cured;
6. Habitual intemperance in the use of ardent spirits, narcotics, or stimulants to such an extent as to incapacitate for performance of professional duties;
7. Holding one's self out to treat human ailments under any name other than his own, or the personation of any other physician;
8. Employment of fraud, deception or any unlawful means in applying for or securing a license, certificate, or state hospital permit to practice the treatment of human ailments in any manner, to practice midwifery, or in passing an examination therefor, or willful and fraudulent violation of the rules and regulations of the department governing examinations;
9. Holding one's self out to treat human ailments by making false statements or by specifically designating any disease, or group of diseases and making false claims of one's skill, or the efficacy or value of one's medicine, treatment or remedy therefore;
10. Professional connection or association with, or lending one's name to, another for the illegal practice by another of the treatment of human ailments as a business, or professional connection or association with any person, firm, or corporation holding himself, themselves, or itself out in any manner contrary to this Act;
11. Revocation or suspension of a medical license in a sister state;
12. A violation of any provision of this Act or of the rules and regulations formulated for the administration of this Act;
13. Except as otherwise provided in Section 16.01, advertisting or soliciting by himself or through another, by means of handbills, posters, circulars, stereopticon slides, motion pictures, radio, newspapers or in any other manner for professional business.
14. Directly or indirectly giving to or receiving from any physician, person, firm or corporation any fee, commisson, rebate or other form of compensation for any professional services not actually and personally rendered. Nothing contained in this subsection prohibits persons holding valid and current licenses under this Act from practicing medicine in partnership under a partnership agreement or in a corporation authorized by "The Medical Corporation Act" as now or hereafter amended or as an association authorized by "The Professional Association Act" as now or hereafter amended, or under "The Professional Corporation Act" as now or hereafter amended, from pooling, sharing, dividing or apportioning the fees and monies received by them or by the partnership, corporation or association in accordance with the partnership agreement or the policies of the Board of Directors of the corporation or association. Nothing contained in this subsection shall abrogate the right of two or more persons holding valid and current licenses under this Act to receive adequate compensation for concurrently rendering professional services to a patient and divide a fee: provided, the patient has full knowledge of the division, and provided that the division is made in proportion to the services performed and responsibility assumed by each.
15. A finding by the Medical Disciplinary Board that the registrant after having his license placed on probationary status violated the terms of the probation.
16. All advertising of medical business which is intended, or has a tendency, to deceive the public or impose upon credulous or ignorant persons and so be harmful or injurious to public morals or safety.
17. All advertising of any medicine or of any means whereby the monthly menses of women can be regulated or reestablished if suppressed.
18. Abandonment of a patient.
19. The use of prescription for use of narcotics or controlled substances (designated products) in any way other than for therapeutic purposes.
20. Promotion of the sale of drugs, devices, appliances or goods provided for a patient in such manner as to exploit the patient for financial gain of the physician.
21. Offering, undertaking or agreeing to cure or treat disease by a secret method, procedure, treatment or medicine, or the treating, operating or prescribing for any human condition by a method, means or procedure which the licensee refuses to divulge upon demand of the Department of Registration and Education.
22. Immoral conduct in practice as a physician, or repeated acts of gross misconduct.
23. Willfully making or filing false records of reports in his practice as a physician.
24. Willful omission to file or record, or willfully impeding the filing or recording or inducing another person to omit to file or record medical reports as required by law.
25. Solicitation of professional patronage by any corporation, agents or persons, or profiting from those representing themselves to be agents of the licensee.
26. Gross and willful and continued overcharging for professional services, including filing false statement for collection of fees for which services are not rendered.
27. Professional incompetence as manifested by poor standards of care or mental incompetency as declared by a court of competent jurisdiction.
28. Physical illness, including, but not limited to,

deterioration through the aging process, or loss of motor skill which results in a physician's inability to practice medicine with reasonable judgment, skill or safety.

All proceedings to suspend, revoke, place on probationary status, or take any other disciplinary action as the Department may deem proper with regard to a license, certificate or state hospital permit on any of the foregoing grounds, except the ground numbered 8 (fraudulent groups expected) must be commenced within 3 years next after the conviction or commission of any of the acts described therein, except as otherwise provided by law; but the time during which the holder of the license, certificate or state hospital permit was without the State of Illinois shall not be included within the 3 years.

The entry of an order or judgment by any circuit court establishing that any person holding a license, certificate or state hospital permit under this Act is a person in need of mental treatment operates as a suspension of that license, certificate or state hospital permit. That person may resume his practice only upon a finding by the Medical Disciplinary Board that he has been determined to be recovered from mental illness by the court and upon the Board's recommendation that he be permitted to resume his practice.

*Amended by P.A. 79-1130, § ;. [Nov. 2] 21. 1075, P.A. 79-13 1434, § eff. Sept. 19, 1976.*

### Listing of name, title, etc.

Section 16.01. Any person licensed under this Act may list his name, title, office hours, address, telephone number and any specialty in professional and telephone directories; may announce by way of a professional card not larger than 3½ inches by 2 inches, only his name, title, degree, office location, office hours, phone number, residence address and phone number and any specialty; may list his name, title, address and telephone number and any specialty in public print limited to the number of lines necessary to state that information; may announce his change of place of business, absence from, or return to business in the same manner; or may issue appointment cards to his patients, when information thereon is limited to the time and place of appointment and that information permitted on the professional card. Listings in public print, in professional and telephone directories or announcements of change of place of business, absence from, or return to business, may not be made in bold faced type.

*Added by act approved July 18, 1967.*

### Medical Disciplinary Board

*Illinois State Medical Disciplinary Board.*] § *16.02.* There is hereby created the Illinois State Medical Disciplinary Board, (hereinafter referred to as the "Board"). The Board shall consist of 7 members, appointed by the Governor by and with advice and consent of the Senate. All shall be residents of the State, not more than 4 of whom shall be members of the same political party. Five members shall be physicians licensed to practice medicine in all of its branches in Illinois. One member shall be an Illinois physician possessing the degree of doctor of osteopathy. One member shall be a person licensed in Illinois and possessing a chiropractor's degree.

a. Of the members of the Board first appointed, two shall be appointed for terms of 2 years, two shall be appointed for terms of 3 years, and three shall be appointed for terms of 4 years. Upon the expiration of the term of any member, his successor shall be appointed for a term of four years by the Governor by and with the advice and consent of the Senate. The Governor shall fill any vacancy for the remainder of the unexpired term by and with the advice and consent of the Senate. Upon recommendation of the Board, any member of the Board may be removed by the Governor for misfeasance, malfeasance, or willfull neglect of duty after notice and a public hearing unless such notice and hearing shall be expressly waived in writing. Each member shall serve on the Board until his successor is appointed and qualified. No member of the Board shall serve more than two consecutive four year terms.

   In making appointments the Governor shall attempt to insure that the various social and geographic regions of the State of Illinois are properly represented.

   In making the designation of persons to act for the several professions represented on the Board, the Governor shall give due consideration to recommendations by members of the respective professions and by organizations therein.

b. The Board shall annually elect one of its members as chairman, one as vice chairman and one as secretary. No officer shall be elected more than twice in succession to the same office. Each officer shall serve until his successor has been elected and qualified.

c. The secretary shall keep a record of the proceedings of the Board and shall be custodian of all books, documents and papers filed with the Board, including the minute book or journal of the Board. The secretary or other persons authorized by the Board may cause copies to be made of all minutes and other records and documents of the Board and may give certificates of the Board to the effect that such copies are true copies, and all persons dealing with the Board may rely upon such certificates.

d. Four members of the Board shall constitute a quorum. A vacancy in the membership of the Board shall not impair the right of a quorum to exercise all the rights and perform all the duties of the Board. Any action taken by the Board under this Act may be authorized by resolution at any regular or special meeting and each such resolution shall take effect immediately. The Board shall meet at least quarterly. The Board is empowered to adopt all rules and regulations necessary and incident to the powers granted to it under this Act.

e. Each member, and member-officer, of the Board shall receive a per-diem stipend as the Director of the Department of Registration and Education. hereinafter referred to as the Director, shall determine. Each member shall be paid his necessary expenses while engaged in the performance of his duties.

f. The Director shall, in conformity with the "Personnel Code," as now or hereafter amended, select a medical coordinator, who shall not be a member of the Board. The medical coordinator shall be a physician licensed to practice medicine

in all of its branches, and the Director shall set his rate of compensation. The medical coordinator shall be the chief enforcement officer of the Medical Practice Act and shall serve at the will of the Board.

The Director shall employ, in conformity with the Personnel Code, not less than one (1) full time investigator for every 5000 physicians licensed to practice medicine in the State. Each investigator shall be a college graduate with at least two years' investigative experience or one year advanced medical education. Upon the written request of the Board, the Director shall employ, in conformity with the Personnel Code, such other professional, technical, investigative, and clerical help, either as a full or part-time basis as the Board deems necessary for the proper performance of its duties. All employees of the Board shall be directed by, and answerable to, the Board with respect to their duties and functions.

g. Upon the specific request of the Board, signed by either the chairman, vice chairman, or medical coordinator of the Board, the Bureau of Drug Compliance, the Office of Professional Supervision of the Department of Registration and Education, the Illinois Law Enforcement Commission, the Illinois Bureau of Investigation, the Illinois Legislative Investigating Commission shall:
   (1) Make available any and all information that they shall have in their possession regarding a particular case then under investigation by the Board.
h. Members of the Board shall be immune from suit in any action based upon any disciplinary proceedings of other acts performed in good faith as members of the Board.

*Added by P.A. 79-1130, § 1, eff. Nov. 21, 1975.*

*Suspension or revocation of license or certificate—Investigation—Notice—Hearing.*] § *17.01* Upon the motion of either the Department or the Board or upon the verified complaint in writing of any person setting forth facts which if proven would constitute grounds for suspension or revocation under Section 16 of this Act, the Department shall, through the Board, investigate the actions of any person, so accused who holds or represents that he holds a license or certificate. Such person is hereinafter called the accused.

The Department shall, before suspending, revoking, placing on probationary status, or taking any other disciplinary action as the Department may deem proper with regard to any license or certificate, at least 30 days prior to the date set for the hearing, notify the accused in writing of any charges made and the time and place for a hearing of the charges before the Board, direct him to file his written answer thereto the Board under oath within 20 days after the service on him of such notice and inform him that if he fails to file such answer default will be taken against him and his license or certificate may be suspended, revoked, placed on probationary status, or have other disciplinary action, including limiting the scope, nature or extent of his practice, as the Department may deem proper taken with regard thereto.

Such written notice and any notice in such proceedings thereafter may be served by delivery of the same personally to the accused person, or by mailing the same by registered or certified mail to the address last theretofore specified by the accused in his last notification to the Department.

*Amended by P.A. 79-1130, § 1, eff. Nov. 21, 1975.*

*Hearings by board—Continuance—Failure to file answer—Disciplinary action—Temporary suspension of license without hearing.*] § *17.02* At the time and place fixed in the notice, the Board provided for in this Act shall proceed to hear the charges and both the accused person and the complainant shall be accorded ample opportunity to present in person, or by counsel, such statements, testimony, evidence and argument as may be pertinent to the charges or to any defense thereto. The Board may continue such hearing from time to time. If the Board is not sitting at the time and place fixed in the notice or at the time and place to which the hearing has been continued, the Department shall continue such hearing for a period not to exceed 30 days.

In case the accused person, after receiving notice, fails to file an answer, his license or certificate may in the discretion of the Director, having received first the recommendation of the Board, be suspended, revoked, placed on probationary status, or the Director may take whatever disciplinary action as he may deem proper, including limiting the scope, nature, or extent of said person's practice, without a hearing, if the act or acts charged constitute sufficient grounds for such action under this Act.

The Board has the authority to recommend to the Director that probation be granted or that other disciplinary action, including the limitation of the scope, nature or extent of a person's practice, be taken as it deems proper. If disciplinary action other than suspension or revocation is taken, the Board may recommend that the Director impose reasonable limitations and requirements upon the accused registrant to insure compliance with terms of the probation or other disciplinary action including, but not limited to, regular reporting by the accused to the Department of his actions, placing himself under the care of a qualified physician for treatment, or limiting his practice in such manner as the Director may require.

The Director may temporarily suspend the license of a physician without a hearing, simultaneously with the institution of proceedings for a hearing provided under this Section if the Director finds that evidence in his possession indicates that a physician's continuation in practice would constitute an immediate danger to the public. In the event that the Director suspends, temporarily, the license of a physician without a hearing, a hearing by the Board must be held within 15 days after such suspension has occurred.

*Amended by P.A. 79-1130, § 1, eff. Nov. 21, 1975.*

*Subpoena of witnesses—Administration of oath.*] § *17.03* The Board or Department has power to subpoena and bring before it any person in this State and to take testimony either orally or by deposition, or both, with the same fees and mileage and in the same manner as is prescribed by law for judicial procedure in civil cases.

The Director, Assistant Director, Superintendent of Registration and any member of the Board each have power to administer oaths at any hearing which the Board or Department is authorized by law to conduct.

*Amended by P.A. 79-1130, § 1, eff. Nov. 21, 1975.*

*Attendance of witnesses and production of books and papers.*] § *17.04* Any circuit court upon the application of the accused person or complainant or of the Department or Board, may order the attendance of witnesses and the production of relevant books and papers before the Board in any hearing relative to the application for or refusal, recall, suspension or revocation of a license or certificate. The court may compel obedience to its order by proceedings for contempt.

*Amended by P.A. 79-1130, § 1, eff. Nov. 21, 1975.*

*Record of proceedings.*] § *17.05* The Department, at its expense, shall provide a stenographer to take down the testimony and preserve a record of all proceedings at the hearing of any case wherein a license or certificate may be revoked, suspended, placed on probationary status, or other disciplinary action taken with regard thereto. The notice of hearing, complaint and all other documents in the nature of pleadings and written motions filed in the proceedings, the transcript of testimony, the report of the Committee and the orders of the Department constitute the record of such proceedings. The Department shall furnish a transcript of such record to any person interested in such hearing upon payment therefor of one dollar per page for each original transcript and 50¢ per page for each carbon copy thereof ordered with the original; except that the charge for any part of such transcript ordered and paid for previous to the writing of the original record thereof shall be 50¢ per page for each carbon copy.

*Amended by P.A. 77-2829, § 34, eff. Dec. 22, 1972; P.A. 78-255, § 61, eff. Oct. 1, 1973.*

*Report of findings and recommendations—Motion for Rehearing—Certificate of order of revocation, suspension, or other disciplinary action.*] § *17.06.* The Board shall present to the Director a written report of its findings and recommendations. A copy of such report shall be served upon the accused person, either personally or by registered or certified mail. Within 20 days after such service, the accused person may present to the Department his motion in writing for a rehearing, which written motion shall specify the particular ground therefor. If the accused person orders and pays for a transcript of the record as provided in Section 17.05, the time elapsing thereafter and before such transcript is ready for delivery to him shall not be counted as part of such 20 days.

At the expiration of the time allowed for filing a motion for rehearing the Director may take the action recommended by the Board. Upon the suspension, revocation, placement on probationary sta tus, or the taking of any other disciplinary action, including the limiting of the scope, nature, or extent of one's practice, deemed proper by the department, with regard to the license, certificate or state hospital permit, the accused shall surrender his license or certificate to the Department, if ordered to do so by the Department, and upon his failure or refusal so to do, the Department may seize the same.

Each certificate of order of revocation, suspension, or other disciplinary action shall contain a brief, concise statement of the ground or grounds upon which the Department's action is based, as well as the specific terms and conditions of such action. This document shall be retained as a permanent record by the Board and the Director.

In those instances where an order of revocation, suspension, or other disciplinary action has been rendered by virtue of a physician's physical illness, including, but not limited to deterioration through the aging process, or loss of motor skill which results in a physician's inability to practice medicine with reasonable judgment, skill, or safety, the Department shall only permit this document, and the record of the hearing incident thereto, to be observed, inspected, viewed, or copied pursuant to court order.

*Amended by P.A. 79-1130, § 1, eff. Nov. 21, 1975.*

*Restoration of license or certificate.*] § *17.07* At any time after the suspension, revocation, placing on probationary status, or taking disciplinary action with regard to any license or certificate, the Department may restore it to the accused person, or take any other action to reinstate the license to good standing, without examination, upon the written recommendation of the Board.

*Amended by P.A. 79-1130, § 1, eff. Nov. 21, 1975.*

*Review under Administrative Review Act—Venue.*] § *17.08* All final administrative decisions of the Department are subject to judicial review pursuant to the provisions of the "Administrative Review Act", approved May 8, 1945, and all amendments and modifications thereof, and the rules adopted pursuant thereto. The term "administrative decision" is defined as in Section 1 of the "Administrative Review Act".

Such proceedings for judicial review shall be commenced in the Circuit Court of the County in which the party applying for review resides; but if such party is not a resident of this State, the venue shall be in Sangamon County.

The Department shall not be required to certify any record to the Court or file any answer in Court or otherwise appear in any Court in a Judicial review proceeding, unless there is filed in the Court with the complaint a receipt from the Department acknowledging payment of the costs of furnishing and certifying the record which costs shall be computed at the rate of 20 cents per page of such record. Exhibits shall be certified without cost. Failure on the part of the Plaintiff to file such receipt in Court shall be grounds for dismissal of the action. During the pendency and hearing of any and all Judicial proceedings incident to such disciplinary action the sanctions imposed upon the accused by the Department shall remain in full force and effect.

*Amended by P.A. 79-1130, § 1, eff. Nov. 21, 1975.*

*Order of revocation or suspension as prima facie evidence.*] § *17.09* An order of revocation, suspension, placing the license on probationary status, or other formal disciplinary action as the Department may deem proper, or a certified copy thereof, over the seal of the Department and purporting to be signed by the Director, is prima facie proof that:

1. Such signature is the genuine signature of the Director;

2. The Director is duly appointed and qualified; and

3. The Board and the members thereof are qualified.

Such proof may be rebutted.

*Amended by P.A. 79-1130, § 1, eff. Nov. 21, 1975.*

*Action and report of board—Reasons of disagreement by Director—Necessity for exercise of powers—Re-examination or re-hearing.*] § *17.10.*

None of the disciplinary functions, powers and duties enumerated in this Act shall be exercised by

the Department except upon the action and report in writing of the Board.

In all instances, under this Act, in which the Board has rendered a recommendation to the Director with respect to a particular physician, the Director shall, in the event that he disagrees with or takes action contrary to the recommendation of the Board, file with the Board and the Secretary of State his specific written reasons of disagreement with the Board. Such reasons shall be filed within 30 days of the occurrence of the Director's contrary position having been taken.

The action and report in writing of a majority of the Board designated is sufficient authority upon which the Director may act.

Whenever the Director is satisfied that substantial justice has not been done either in an examination, or in a formal disciplinary action, or refusal to restore a license or certificate, he may order a re-examination or re-hearing by the same or other examiners.

*Amended by P.A. 79-1130, § 1, eff. Nov. 21, 1975.*

*Confidentiality of information received at hearings.*] § *17.11* In all hearings conducted under this Act, information received, pursuant to law, relating to any information acquired by a physician in attending any patient in a professional character, necessary to enable him professionally to serve such patient, shall be deemed strictly confidential and shall only be made available either as part of the record of such hearing or otherwise; (1) when such record is required, in its entirety, for purposes of judicial review pursuant to this Act; or (2) upon the express, written consent of the patient, or in the case of his death or disability, of his personal representative.

*Added by P.A. 79-1130, § 1, eff. Nov. 21, 1975.*

*Liability for disciplinary action without reasonable basis in fact.*] § *17.12* In the event that the Department's order of revocation, suspension, placing the licensee on probationary status, or other order of formal disciplinary action is without any reasonable basis in fact of any kind, then the State of Illinois shall be liable to the injured physician for those special damages he has suffered as a direct result of such order.

*Added by P.A. 79-1130, § 1, eff. Nov. 21, 1975.*

*Report of violations—Immunity from liability—Assistance in medical competency examinations—Hearing officers.*] § *17.13* Any physician licensed under this Act, the Illinois State Medical Society, the Illinois Osteopathic Association, the Chiropractic Association, or any component societies of any of these three groups, and any other person, may report to the Board any information such physician, association, society, or person may have which appears to show that a physician is or may be in violation of any of the provisions of Section 16 of the Medical Practice Act. Any such physician, association, society or person, participating in good faith in the making of a report, under this Act, shall have immunity from any liability, civil, criminal, or that otherwise might result by reason of such actions. For the purpose of any proceedings, civil or criminal, the good faith of any such physician, association, society or persons shall be presumed. The Board may request the Illinois State Medical Society, the Illinois Osteopathic Association, or the Illinois Chiropractic Association both to assist the Board in preparing for or conducting any medical competency examination as the Board may deem appropriate. The Board shall retain and use such hearing officers as it deems necessary.

*Added by P.A. 79-1130, § 1, eff. Nov. 21, 1975.*
*Amended by P.A. 80-965, § 1, eff. Sept. 22, 1977.*

*Punishment for doing certain acts without license.*] § *24.* If any person holds himself out to the public as being engaged in the diagnosis or treatment of ailments of human beings; or suggests, recommends or prescribes any form of treatment for the palliation, relief or cure of any physical or mental ailment of any person with the intention of receiving therefor, either directly or indirectly, any fee, gift, or compensation whatsoever; or diagnosticates or attempts to diagnosticate, operate upon, profess to heal, prescribe for, or otherwise treat any ailment, or supposed ailment, of another; or maintains an office for examination or treatment of persons afflicted, or alleged or supposed to be afflicted, by any ailment; or attaches the title Doctor, Physician, Surgeon, M.D. or any other word or abbreviation to his name, indicating that he is engaged in the treatment of human ailments as a business; and does not possess a valid license issued by the authority of this State to practice the treatment of human ailments in any manner, he shall be sentenced as provided in Section 35.1.

Amended by P.A. 77-2708, § 1, eff. Jan. 1, 1973.

## Physician's Assistant Act

*Section 1.* The purpose and legislative intent of this Act is to encourage and promote the more effective utilization of the skills of physicians by enabling them to delegate certain health tasks to physician's assistants where such delegation is consistent with the health and welfare of the patient and is conducted at the direction of and under the responsible supervision of the physician.

*Section 2.* This Act shall be known and may be cited as the "Physician's Assistants Practice Act."

*Section 3.* "Physician's assistant" means any person not a physician who is certified to perform medical procedures under the supervision of persons licensed to practice under "The Medical Practice Act." A physician's assistant may perform such medical procedures within the specialty of the supervising physician, except that such physician shall exercise such direction, supervision and control over such physician's assistants as will assure that patients receiving medical care from a physician's assistant shall receive medical care of the highest quality. Physician's assistants shall be capable of performing a variety of tasks within the specialty of medical care under the supervision of a physician, although the physician's assistant does not possess the level of medical knowledge necessary to integrate and interpret findings. Physician's assistants cannot exercise independent judgment for purposes of diagnosis and treatment of patients. Nothing in this Act shall be construed as relieving any physician of the professional or legal responsibility for the care and treatment of persons attended by himself or by physician's assistants under his supervision. Physician's assistants shall have only those powers and rights set forth in this Act and the exercise of any powers beyond those set forth shall constitute a violation of this Act.

*Section 4.* No physician's assistant shall use the title of doctor or associate with his name any other term which would indicate to other persons that he is qualified to engage in the general practice of medicine. A physician's assistant shall not be allowed to bill patients or in any way to charge for

services. Nothing in this Act, however, shall be so construed as to prevent the employer of a physician's assistant from charging for services rendered by the physician's assistant. The physician shall file with the Department notice of employment and discharge of the physician's assistant at the time of said employment or discharge.

*Section 5.* No more than one physician's assistant shall be employed by a physician. Physician's assistants shall be employed only under the supervision of persons licensed to practice under "The Medical Practice Act" and engaged in private clinical practice, or in clinical practice in public health or other community health facilities.

*Section 6.* Each applicant for a physician's assistant certificate shall:

1. Make application for examination on forms prepared and furnished by the Department of Registration and Education.

2. Submit evidence under oath satisfactory to the Department that:

(a) He is 21 years of age or over;

(b) He is of good moral character;

(c) He has the preliminary and professional education required by this Act;

(d) He is free of contagious diseases.

3. Designate specifically the name, location, and kind of professional schools, colleges, or institutions attended and the courses which he has satisfactorily completed.

4. Pay to the Department of Registration and Education at the time of application, an examination fee of $25. The fee for subsequent renewal of a certificate without lapse shall be $15.

*Section 7.* Except as otherwise provided in this Act, the minimum standards of educational requirements prior to the taking of an examination shall consist of the following:

(a) Successful completion of a 4 year course of instruction in a high school, or its equivalent, as determined by the examining committee; and

(b) Successful completion of a specialized course for physician's assistants consisting of not less than 20 months instruction in any 2 year period; such course and the institution or school offering the same shall be approved by the examining committee provided for in this Act.

The examining committee shall have the power to waive the specialized training provided for in this Section, if the committee determines that any prior training and experience of the applicant is the equivalent of such specialized training.

*Section 8.* Registered nurses in the State of Illinois may take such examination without completing any additional courses of study and shall be issued a certificate upon the passage of such examination.

*Section 9.* Subject to the provisions of this Act, the Department of Registration and Education shall:

1. Promulgate rules approved by the examining committee setting forth standards to be met by a school or institution offering a course of training for physician's assistants prior to approval of such school or institution.

2. Promulgate rules approved by the examining committee setting forth uniform and reasonable standards of instruction, including but not limited to specific subjects taught, to be met prior to approval of such course of instruction for physician's assistants.

3. Determine the reputability and good standing of such schools or institutions and their course of instruction for physician's assistants by reference to compliance with such rules, provided that no school of physician's assistants that refuses admittance to applicants solely on account of race, color, sex, or creed shall be considered reputable and in good standing.

4. Prescribe rules for examining candidates for a certificate as physician's assistant.

5. All examinations provided for by this Act shall be conducted under rules and regulations prescribed by the Department of Registration and Education. Examinations shall be held at least 3 times a year at times and places to be determined by the Department.

No rule or regulation shall be adopted under this Act which allows a physician's assistant to perform any act, task or function primarily performed in the lawful practice of optometry under "The Illinois Optometric Practice Act," approved June 15, 1951, as amended.

*Section 10.* Upon the satisfactory completion of application and examination procedures and compliance with the applicable rules and regulations of the Department of Registration and Education, the Department shall issue a physician's assistant certificate to the qualifying applicant.

*Section 11.* The Medical Examining Committee of the Department of Registration and Education as provided in Section 60-a of "The Civil Administrative Code of Illinois," approved March 17, 1917, as amended, may revoke or withdraw the certificate issued under this Act upon any of the following grounds:

1. Conviction in this or another state of any crime which is a felony under the law of this State, or conviction of a felony in a federal court;

2. Gross malpractice resulting in permanent injury or death of a patient;

3. Engaging in dishonorable, unethical or unprofessional conduct of a character likely to deceive, defraud or harm the public;

4. Habitual intemperance in the use of alcohol, narcotics or stimulants to such an extent as to incapacitate for performance of professional duties.

5. Employment of fraud, deception or any unlawful means in applying for or securing a certificate as a physician's assistant;

6. Exceeding the authority delegated to him by his employing physician;

7. A violation of any provisions of this Act or of the rules and regulations formulated for its administration.

*Section 12.* No action of a disciplinary nature which is predicated on charges alleging unethical or unprofessional conduct of a person who practices as a physician's assistant and which can be reasonably expected to affect adversely that person's maintenance of his present, or his securing of future, employment as such a physician's assistant may be taken by the Department of Registration and Education, by any association, or by any person unless the physician's assistant against whom such charges are made is afforded the right to be represented by legal counsel of his choosing and to present any witness, whether an attorney or otherwise, to testify on matters relevant to such charges.

*Section 13.* Certificates may be revoked or suspended only in the manner provided by Section 60b through 60h inclusive of "The Civil Administrative Code of Illinois," approved March 7, 1917, as now or hereafter amended.

*Section 14.* All final administrative decisions of the Department of Registration and Education are subject to judicial review pursuant to the provisions of the "Administrative Review Act," approved May 8, 1945, and all amendments and modifications thereof, and the rules adopted pursuant thereto. The term "administrative decision" is defined in Section 1 of the "Administrative Review Act."

*Section 15.* All certificates issued under this Act must be renewed every 2 years after their issuance and the examining committee may require a physician's assistant to submit to a mental or physical examination at any time felt necessary by the examining committee.

*Section 16.* No person shall use the title or perform the duties of "physician's assistant" unless he is a qualified holder of a certificate as provided in this Act. A certified physician's assistant shall wear on his person a visible identification indicating that he is certified as a physician's assistant while acting in the course of his duties.

*Section 17.* The Medical Examining Committee of the Department of Registration and Education shall review the provisions of this Act to determine its effectiveness and accomplishments and shall solicit the cooperation and advice of such public and private agencies as the Committee may deem proper. The Committee shall report its findings and recommendations to the Governor and the General Assmbly on January 1, 1980.

*Section 18.* This Act takes effect July 1, 1976.

*Section 19.* This Act is repealed on June 30, 1981.

---

## DIVISION OF VOCATIONAL REHABILITATION

623 East Adams Street
Springfield, IL 62706
James S. Jeffers, *Director*

The Board of Vocational Rehabilitation is a statutory body, established to administer, through one division, the state program of vocational rehabilitation pursuant to the Federal Vocational Rehabilitation Act, as amended.

# Medical Legal Information

(Prepared by ISMS Corporate Counsel)

*The purpose of this article is to present to the Illinois medical community a general view of certain medical-legal principles and relationships which many physicians may encounter in the ordinary practice of their profession. Because this article is intended to provide information of a general nature only, specific problems should be discussed with one's individual attorney. While this presentation is not all-inclusive, it will afford an insight into the more common considerations. It should not be construed as presenting legal opinion, rather general considerations. Information is intended to be illustrative only and does not establish or imply a standard of care.*

## ISMS LEGAL SERVICES

The Illinois State Medical Society retains, on a continuing basis, a corporate counsel to whom the Society refers legal questions affecting the membership as a whole. ISMS also answers specific inquiries made by the component county medical societies when they are of general interest to the medical community. Although the Illinois State Medical Society does not provide personal legal advice to individual members, the Society does believe the following information will help further each physician's awareness of certain basic legal principles and concepts vital to his practice.

## THE PHYSICIAN-PATIENT RELATIONSHIP

### *Contractual Relationship*

In most instances the physician-patient relationship is a voluntary, contractual one. Accordingly, physicians are required to accept only those patients they elect to treat. The professional services rendered on behalf of particular patients and the fees compensating the physician for those services are to be agreed between the physician and the patient. Whenever possible, the physician should discuss his fee with the patient in advance of treatment.

While a physician is free to determine who will be his patients, once the physician has undertaken the treatment of a particular patient, he is under a legal duty, subject to certain exceptions discussed below, to continue his attendance so long as the case requires attention.

A physician may legally terminate his attendance of a particular case in several ways:

1. The contract between the physician and the patient expressly limits the scope of treatment;

2. The patient may discharge the physician;

3. The relationship may end by mutual consent;

4. The physician may legally terminate his services if the patient breaks the contract by failing to observe the medical directives of the physician, or does not pay for the services rendered.

When the physician has a reasonable basis to terminate his care of the patient, he must provide the patient with sufficient, reasonable notice of his intention to withdraw so as to enable the patient to secure another physician. This notice should be in writing and briefly explain to the patient the reason for the intended termination. If the patient returns to the attending physician, and has been unable to procure other medical assistance, the attending physician should *not* refuse continued treatment until a replacement has been secured. Upon request, the physician should make copies of his records of the care he rendered to the patient available to a new physician selected by the patient.

## HOSPITAL PATIENT RECORDS

Illinois law provides that hospitals in the state shall, upon the written demand of any discharged patient, permit that patient, the patient's physician or authorized attorney to examine and make copies of his medical records. With few exceptions, these disclosure provisions do *not* apply in the case of a psychiatrist-patient relationship. With respect to the physician's office records, the statute was amended in 1976 to provide that every physician shall, upon the demand of any patient who has been treated by him, permit the patient's attorney or physician who is currently treating him to examine and copy all medical records in connection with the treatment of the patient. Psychiatric records are excluded, except when ordered by a Court. The physician to whom the request is directed must respond within a reasonable time and shall be reimbursed by the patient or his representative for all reasonable costs resulting from examining or duplicating the physician's records.

## NEGLIGENCE LIABILITY OF PHYSICIANS

Illinois law requires physicians and surgeons to exercise that degree of reasonable skill as is used in ordinary good practice. The failure to exercise such skill will result in liability if the patient is thereby injured.

In recent years, in part through the adoption of new laws, but primarily through court decisions, professional liability has been significantly expanded. A recent ruling of the Illinois Supreme Court, for example, extended liability in a certain circumstance for birth defects suffered by a child as a consequence of an injury its mother suffered eight years before the child was conceived. The Court reasoned that the defendant hospital and doctor should have known that the harm caused the mother could have resulted in injury to the child born many years later. This case establishes a "chain of accountability" which dramatically increases the doctor's liability and underscores the fact that the problems associated with medical malpractice continue to jeopardize the delivery of quality medical care.

The physician is liable for his own negligent acts and the negligent acts of all employees subject to his control or supervision while acting within the scope of their employment. In the case of a partnership, he also may be liable for the negligent acts of his partners.

Today there is simply no existing alternative to carrying adequate liability insurance. However, insurance coverage is not a panacea for expanded liability. Each physician must undertake affirmative efforts to reduce the risks associated with the rendering of health care services.

The American Medical Association published a pamphlet entitled "Professional Liability and the Physician." Twenty guidelines for preventing malpractice actions are set forth in that pamphlet:

1. The physician must care for every patient with scrupulous attention given to the requirements of good medical practice.

2. The physician must know and exercise his legal duty to the patient.

3. The physician must avoid destructive and unethical criticism of the work of other physicians.

4. The physician must keep records which clearly show what was done and when it was done and which demonstrate that the care given met fully the standards of good care as practiced in the community or in similar communities. If any patient discontinues treatment before he should, or fails to follow instructions, the records should show it; a good method is to preserve a carbon copy of the physician's letter advising the patient against the unwise course.

5. A physician must avoid making any statement which constitutes, or might be construed as constituting, an admission of fault on his part. He should instruct employees to make no such statements.

6. The physician must exercise tact as well as professional ability in handling his patients, and should insist on a professional consultation if the patient is not doing well, if the patient is unhappy and complaining, or if the family's attitude indicates dissatisfaction.

7. The physician must refrain from over-optimistic prognoses.

8. The physician must advise his patients of any intended absences from practice and recommend, or make available, a qualified substitute. The patient must not be abandoned.

9. The physician must unfailingly secure a consent, in writing, for medical and surgical procedures and for autopsy.

10. The physician must carefully select and supervise assistants and employees and take great care in delegating duties to them.

11. The physician should limit his practice to those fields which are well within his qualifications.

12. The physician must frequently check the condition of his equipment and make use of every available safety installation.

13. The physician should make every effort to reach an understanding with his patient in the matter of fees, preferably in advance of treatment

14. The physician must realize that it is dangerous to diagnose or prescribe by telephone.

15. The physician should not sterilize a patient solely for the patient's convenience, except after a complete explanation of the procedure and its risks and possible complications. He must also first obtain a signed consent from the patient and from the patient's spouse, if the patient is married. Eugenic sterilization should be performed

only in conformity with the law of the state, if any. Sterilization for therapeutic purposes may be performed lawfully with the consent of the patient and preferably with the consent of the patient's spouse, if the patient is married.

16. Except in an actual emergency situation which makes it impossible to avoid doing so, a male physician should not examine a female patient unless an assistant or nurse, or a member of the patient's family is present.

17. The physician should exhaust all reasonable methods of securing a diagnosis before embarking upon a therapeutic course.

18. The physician should use conservative and less dangerous methods of diagnosis and treatment wherever possible, in preference to highly toxic agents or dangerous surgical procedures.

19. The physician should read the manufacturer's brochure accompanying a toxic agent to be used for diagnostic or therapeutic purposes and, in addition, should ascertain the customary dosage or usage in his area.

20. The physician should be aware of all the known toxic reactions to any drug he uses, together with the proper methods for treating such reactions.

In addition to these general guidelines to good medical practice, the physician should keep current and be in compliance with hospital regulations and standards enforced by governmental agencies, the Joint Commission on Accreditation of Hospitals, and the bylaws of his hospital and its medical staff. The physician has the responsibility to maintain good records of his care of his patients, to recommend consultation when the advice of a specialist is indicated, and to keep his patients informed of the progress of their care. The physician, as a member of an organized hospital medical staff, also has the duty to participate in, and submit to, peer review for purposes of monitoring his professional credentials and performance and for evaluating the quality and appropriateness of the patient care he delivers.

## ILLINOIS CONTROLLED SUBSTANCES ACT

Under the Illinois Controlled Substances Act, physicians who prescribe or dispense various controlled substances are required to register with the Illinois Department of Registration and Education. Categories of drugs under which registration is required are almost identical to those established by the Federal DEA.

## LIMITS ON LIABILITY—SPECIAL SITUATIONS

Under the "Good Samaritan" amendment to the Medical Practice Act, physicians who, in good faith provide emergency care without fee to a person, shall not, as a result of acts or omissions, except willful or wanton misconduct, be liable for civil damages.

The Medical Practice Act further provides that any physician, serving on any medical utilization committee, medical review committee, or peer review committee shall not be liable for civil damages as a result of his acts, or omissions, or decisions in connection with his duties on such committee, except those acts, omissions or decisions which involve willful or wanton misconduct. There are cases before the Illinois Courts challenging these grants of immunity and the ISMS is monitoring and cooperating in the defense of these lawsuits.

## AUTOPSY

The *Illinois Revised Statutes* specifically detail the conditions under which a physician may perform an autopsy. Essentially, an autopsy may be performed provided:

1. The physician has a written authorization from the decedent to do so; or
2. The physician has a written authorization from a surviving relative who has the right to determine the method for disposing of the body or a next of kin or other person who has such right (a "surviving relative" means the spouse, an adult child, the parent, or an adult brother or sister of the decedent); or
3. The physician has a telegraphic or telephonic authorization from a surviving relative who has the right to determine the method for disposing of the body or a next of kin or other person who has such right. This last provision is conditioned, however, upon the requirement that the telegraphic or telephonic authorization is verified, in writing, by at least two persons who were present at the time and place the authorization was received.

Illinois law specifically provides that where two or more persons have equal right to determine the method for disposing of the body, the authorization of only one such person shall be necessary, unless, before the autopsy is performed, any others having such equal right shall object in writing or, if not physically present in the community where the autopsy is to be performed, by telephonic or telegraphic communication to the physician by whom the autopsy is to be performed.

While authorization may be given to a physician or hospital administrator or his duly authorized representative, only a physician shall perform the autopsy. The authorized personnel of a hospital or other qualified personnel selected by a physician may assist a physician performing an autopsy.

The term "written authorization", provided for above, means any printed, typed or handwritten communication signed by the person granting the authorization.

It is important to emphasize that, in Illinois, the heirs and next of kin can bring an action for mutiliation of the body of a decedent in those cases in which an autopsy is performed without authority or permission. In order to avoid the possibility of liability, autopsies should only be performed when ordered by the coroner or upon the appropriate written consent of the next of kin as specified above. (The coroner may order an autopsy directly against the wishes of the next of kin). Cooperation should be forth-coming in cases under the Coroner's jurisdiction.

## DEATH

Since the controversy generated by the Karen Quinlan case (New Jersey); and the Joseph Saikowicz case (Massachusetts) much has been written about the physician's role in determining death. Some states, Kansas and California, for example, have adopted special legislation in an attempt to "regulate" the legal and medical definitions of death and to provide so-called, "death with dignity" guarantees. To date, similar laws are not "on the books" in Illinois and, at present, the law of our state continues to provide that death occurs when in the judgment of the physician, there has been irreversible cessation of spontaneous vital functions (heart beat and respiration).

## CONSENT OF MINORS TO MEDICAL TREATMENT

**1. Situations Where Consent Need Not Be Obtained For Treatment of a Minor:** Whenever a hospital or a physician renders emergency treatment or first aid (or a licensed dentist renders emergency dental treatment) to a minor, consent of the minor's parent or legal guardian need not be obtained if, in the sole opinion of the physician, dentist or hospital, the obtaining of consent is not reasonably feasible under the circumstances without causing a delay which could adversely affect the condition of such minor's health.

**2. Parental Consent for Treatment of a Minor Child When Parent is Also a Minor:** Illinois law provides that any parent, including a parent who is a minor, may give his or her consent to the performance upon his or her child of a medical or surgical procedure by a physician licensed to practice medicine and surgery or a dental procedure by a licensed dentist. The consent of such parent is not voidable because of his or her minority, and Illinois law specifically provides that this parent, who is a minor, is deemed to have the same legal capacity to act and shall have the same powers and obligations as has a person of legal age.

The consent to the performance of a medical or surgical procedure, by a physician licensed to practice medicine and surgery, which is executed by a married person who is a minor or by a pregnant woman who is a minor, is not voidable because of such minority and Illinois law further provides that for such purpose, such married person, who is a minor, or such pregnant woman, who is a minor, is deemed to have the same legal capacity to act and has the same powers and obligations as has a person who has attained majority (age 18 or older).

**3. Birth Control Services for Minors:** Birth control services and information may be rendered by doctors licensed in Illinois to practice medicine in all of its branches to any minor who meets any of the following criteria: is married; is a parent; is pregnant; has the consent of parent or legal guardian; as to whom the failure to provide such services would create a serious health hazard; or is referred for such services by a physician, clergyman or a planned parenthood agency.

**4. Venereal Disease and Drug Use—Consent to Treatment By Minor:** Illinois law specifically provides that a minor, 12 years of age or older, who may have come into contact with any venereal disease or who is suffering from the use of depressant or stimulant drugs or narcotic drugs (as defined in Controlled Substances Acts), may give his or her own binding consent, which is not later voidable, to the furnishing of medical care or counselling related to the diagnosis or treatment of such disease or addiction. Each incident of venereal disease shall be reported to the State Department of Public Health or the local board of health in accordance with existing regulations. Illinois law specifically states that the consent of the parent, parents, or guardian of such minor, receiving such treatment or counselling, shall not be necessary to authorize the care or counselling which is related to the diagnosis or treatment of such disease or drug or narcotic use.

Any physician who provides diagnosis or treatment to a minor patient who has come into contact with any venereal disease or suffers from the use of any drug or narcotic, referred to above, may, but shall not be obligated to, inform the parent, parents or legal guardian of any such minor as to the treatment given or needed.

## UNEMPLOYMENT COMPENSATION

The Illinois Unemployment Compensation law has been expanded so that it now includes coverage by physicians who employ only one person. This liability was discussed at some length in the "Practice Management" section of the July, 1973, issue of the *Illinois Medical Journal*. If physicians have specific questions regarding the applicability of unemployment compensation to their employees, they should consult the Illinois Department of Labor, Division of Unemployment Compensation, or their attorney.

## BLOOD LABELING

The Illinois Blood Labeling Act contains three requirements of particular importance to the medical profession:

1. No person may administer blood by transfusion in Illinois unless the container of such blood is labeled in conformity with regulations developed and specified by the Illinois Department of Public Health;

2. When blood is administered by transfusion in Illinois, the identification number of the unit of blood must be recorded in the patient's medical record and the label on the container of blood may not be removed before or during the administration of that blood by transfusion;

3. As of July 1, 1973, no blood (which has been initially acquired by purchase) may be administered by transfusion in Illinois unless:

a. The physician in charge of the treatment of the patient to whom the blood is to be administered has directed that such purchased blood be administered to that patient; and

b. The physician in charge of the treatment of the patient has specified in the patient's medical record his reason for such action.

## IMMUNIZATION

In 1972, legislation was passed to eliminate the requirement of smallpox immunization and to add rubella to the list of diseases against which there must be immunization.

The 1973 session of the Illinois General Assembly, however, eliminated a listing of specific diseases against which there must be immunization and transferred responsibility for determination of these to the Illinois Department of Public Health. Thus, the director will promulgate regulations, which may change from time to time, as to those diseases against which children will be immunized. This affects the School Code and the Communicable Disease Act.

## MEDICAL CORPORATIONS

Until 1963, when the Illinois General Assembly passed the Medical Corporation Act, physicians were not able to avail themselves of the legal advantages of doing business as a corporation. A primary reason for forbidding the use of the corporate form for doctors was that the personal assets of the officers, directors and stockholders are generally beyond the reach of creditors, including persons who acquire a legal claim against the corporation after suffering injury resulting from the actions of the agents of the corporation. Because the public wished to insure itself of the best medical care, the law would not permit doctors to insulate themselves from personal malpractice liability by the use of a "corporate shield." However, the Corporation can be sued as the employer and the individual doctor-employee can also he sued.

The corporate form does, however, present certain advantages, particularly in the area of taxation. There has never been a compelling reason to deny these benefits to doctors and other professionals.

Under the Illinois law, all the shareholders, officers and directors of a medical corporation must be licensed physicians. In the case of a professional services corporation also authorized under current Illinois law, the secretary of the corporation need not be a physician.

The corporation must register with the Illinois Department of Registration and Education under whose auspices it is permitted to operate, in addition to the requirements of filing with the office of the Secretary of State. This law explicitly denies physicians working within a corporation the right to insulate their personal assets from malpractice liability.

Tax consequences are the primary factors in determining the wisdom of incorporation. In an article written for the November, 1970, issue of the *Illinois Bar Journal* Linscott R. Hanson summarized the advantages of incorporation. Among the major advantages listed were:

1. Deductability by employees of a portion of their sick pay.
2. Deductability as a corporate business expense of the full cost of employee accident and health insurance.
3. Deductability as a corporate business expense of medical payments in excess of insurance.
4. Lower corporate tax rates for funds to be re-invested in the business.
5. Relatively easy adjustment of ownership percentages.
6. Avoidance of many probate problems upon the death of a practitioner and the avoidance of having to create a whole new business as when a partner dies.
7. Liability limitation, other than for malpractice, to the investment in the corporation thus reducing investors' risks.
8. Miscellaneous pension and profit-sharing tax advantages.

There are also some disadvantages or requirements associated with incorporation, as follows:

1. Since a corporation is a separate legal entity, there are certain minimal requirements necessary "to give life and credibility" to the corporate form (record keeping; governance; etc.). Simply declaring yourself a corporation is not enough; the law requires that you operate in accordance with laws governing corporate organizations. Occasionally problems can arise and the physician may incur costs of legal defense in his dealings with the Internal Revenue Service and other governmental bodies as when they challenge his activities carried out in the name of the corporation.
2. Corporations produce other unique costs as well, including additional social security taxes; corporate franchise taxes; capital stock and personal property taxes; increased state income taxes; state licensing fees; and other taxes and fees.
3. Corporations usually generate higher administrative and legal costs.
4. Corporations are subjected to many state and federal laws and regulations.

Certainly each practitioner, physician and partnership should consider the merits of incorporating. The purpose here has been to give a brief explanation so that each interested physician can receive a general over-view of his options. A tax specialist should, of course, be consulted to review the particulars of each business situation.

## MDs EXCLUDED FROM 'CERTIFICATE OF NEED' CONTROLS

Plans to build, expand, move or sell a hospital, nursing home or surgicenter require approval of the State Health Facilities Planning Board.

A provision in the original legislation which would have brought physicians' offices and clinics under "certificate of need" regulation was withdrawn because of vigorous ISMS opposition. At the federal level, renewed efforts are underway to bring all outpatient facilities, including the doctor's office, under the provisions of the law.

This law covers construction or modification plans involving an expenditure of more than $150,000, or a substantial change in services or bed capacity.

Under Public Law 93-641, local Health Services Agencies are to hold public hearings on all applications for construction or expansion of facilities before submitting a recommendation to the state Health Planning Board for final action.

The state agency is required to study: (1) area size; (2) population and growth potential; (3) number of existing and planned facilities offering similar services; (4) utilization of existing facilities; (5) availability of alternative facilities and services; and, (6) availability of necessary personnel.

Undoubtedly, the role of health planning agencies will expand and the physician will feel the effects and influ-

ence of regulations promulgated by these organizations. While the private practice of medicine is as yet relatively "free" of the jurisdiction of these agencies, the decisions of the Board are already reaching out to limit the purchase of new equipment and the development of new services by hospitals and other institutions in which the doctor performs many of his professional services. It is reasonable to expect that with the current government emphases on cost containment in health care, the physician's practice can and will be affected. Therefore, it is in each physician's best interest to monitor these developments closely in the months and years ahead.

## CURRENT DEVELOPMENTS IN HEALTH LAW

The practice of medicine has been subjected to increasing regulation at all levels of government. At the federal level, in addition to HEW, many other agencies are making administrative decisions and promulgating rules and regulations which impact upon the physician and his practice environment. For example, the Federal Trade Commission is investigating the collective activities of doctors which may have had an anti-competitive or anti-consumer result. The pressure is mounting in favor of liberal policies permitting advertising of medical services and for expanding the role of para-professional groups in the delivery of health care.

At the state and local levels, generic drug substitution laws, statutes authorizing the administration of Laetrile and other substances and other consumer-oriented legislation has been widely adopted.

In response to these initiatives, the Illinois State Medical Society, by action of its Board of Trustees, developed a program of legal assistance for its members. This Legal Assistance Plan has been approved by the Internal Revenue Service so as to avoid any jeopardy to the tax exempt status of the Society. The Plan will provide legal assistance, funded by the Society, in limited circumstances when the legal issue at stake is of such universal and important consequence as to affect the rights, not only of the individual physician who is a party to the litigation or administrative proceedings, but to all members of organized medicine. The Executive Committee of the Board acts as a review body to receive written requests for legal assistance and to evaluate each request on its merits. To date, the Society has approved assistance in several cases and has authorized legal counsel to file friend-of-the-court briefs in two lawsuits in which legal issues of considerable significance to practicing physicians were raised.

# INDEX TO REFERENCE SECTION


A

Accreditation, Committee on ....257
Administration, Division of ....247
Affiliate Societies, Council on ....236
Alcoholism and Drug Dependence, Committee on ...239
American Association of Medical Assistants, Illinois Society ....255
Ancillary Organizations ....254
Autopsy ....283

B

Benevolence, Committee on Finance and Medical ...241
Blood Labeling ....284
Board of Trustees, Committees of ....241
Bylaws ....205

C

Certificate of Need ....285
Children and Family Services, Department of ....264
CME Sponsors, Accredited ....257
Committees—
Trustee District ....233
*(See Specific Committees)*
Computer Services, Division of ....247
Constitution and Bylaws ....205
Committee on ....241
Index to ....216
Continuing Medical Education, Illinois Council on ..256
Cost Effectiveness, Task Force on ....244
Councils of the Illinois State Medical Society ....236
Organization Chart ....235
Current Developments in Health Law ....286

D

Dangerous Drugs Commission ....265
Direct Reporting Committees ....243
District Committees, Trustee ....233
Drugs and Therapeutics, Committee on ....243

E

Economics and Peer Review, Council on ....236
Education Programs, Paramedical, Accredited (Schools) ....261
Education and Manpower, Council on ....237
Education, Manpower and Convention Services, Division ....248
Educational and Scientific Foundation ....256
Ethical Relations Committee ....241
Ethics, Principles of Medical ....204
Executive Committee ....241
Eye Health Committee ....237

F

Field Services, Division of ....248
Finance and Medical Benevolence Committee ....241
Foundation for Medical Care, Illinois ....258

G

Generic Prescribing Law, Ad Hoc Committee on ....240
Governmental Affairs,
Council on ....237
Division ....248

H

Health Planning, Committee ....243
Hospital Patient Records ....282
House of Delegates, ISMS ....231

I

Illinois Controlled Substances Act ....283
Illinois Cooperative Health Data Systems ....245
Illinois Council on Continuing Medical Education ..256
Illinois Foundation for Medical Care ....258
Illinois Medical Political Action Committee (IMPAC).259
Illinois Medical Student Loan Fund ....251
Illinois Society, American Association of
Medical Assistants ....255
Illinois State Government ....263
Department of
Children and Family Services ....264
Mental Health ....264
Public Aid ....266
Public Health ....266
Registration and Education ....271
Vocational Rehabilitation Division ....281
Illinois State Medical Insurance Services ....259
Illinois State Medical Society Organization ....246
Illinois State Medical Society Services ....247
Immunization ....285
Impartial Medical Testimony ....252
INA/ISMS Joint Practice Committee ....245
ISMS Auxiliary ....254
Advisory Committee, to the ....242
Insurance, Committee on ....243
Insurance Programs, Sponsored ....236

L

Laboratory Services, Committee on ....238
Legal Services, ISMS ....281
Liability, Limits on ....283
Loan Fund Program ....251

M

Maternal Welfare, Committee on ....240
Medical Corporations ....285
Medical and Paramedical Education ....260
Medical Assistants, American Association of ....255
Medical Ethics, Principles of ....204
Medical Legal Council ....238
Medical Legal Information ....281
Medical Practice Act ....272
Medical Schools in the State of Illinois ....260
Medical Services, Council on ....239
Medical Services, Division of ....249
Mental Health and Developmental Disabilities,
Department of ....264
Mental Health and Addiction, Council on ....238
Minors to Medical Treatment, Consent of ....284
Multiphasic Testing and Screening ....229

N

Negligence and Liability of Physicians ....282

O

On the Legislative Scene ....250
Organization Chart, ISMS Council ....235

P

Peer Review Appeals Committee ....236
Physician Recruitment and Student Loan Fund
Programs ....251
Physicians Assistants ....279
Physician-Patient Relationship ....281
Poison Control Centers ....270
Policy Committee ....242
Policy Manual of ISMS ....217
Principles of Medical Ethics ....204
Private Health Insurance, Committee on ....236
Professional Liability Insurance Program ....259
Professional Liability, Task Force on ....244
Public Affairs, Committee on ....237
Public Aid, Department of ....266
Public Health, Department of ....266
Poison Control Centers ....270
Renal Dialysis ....271
Public Relations and Membership Services, Division of.250
Public Relations and Membership Services, Council on.239
Publications Committee ....242
Publications, Medical Legal, and Mental Health,
Division of ....249

R

Registration and Education, Department of ....271
Medical Disciplinary Board ....271
Medical Examining Committee ....271
Medical Practice Act ....271
Renal Dialysis Centers and Units ....271
Representatives to Other Groups ....245
Resident Physician Section ....260
Revisions of Disciplinary and Peer Review Procedures,
Ad Hoc Study Committee on ....244

S

Scientific Speakers Bureau ....251
Services, ISMS ....247
Services, Legal ....281
Specialty Societies, Division of ....250
Staff Organization Chart ....246
State Technical Advisory Committee,
Illinois Jail Health Program ....240
Student Business Session ....259
Student Loan Fund Board ....251

T

Third Party Payment Processes Committee ....242
Trustee District Committees ....233
Trustee Districts Map ....232

U

Unemployment Compensation ....284

V

Vocational Rehabilitation, Division of ....281

W

Workmen's Compensation, Committee on ....240

# '78 Legislative Session Marked By Firsts

Each year, the Illinois General Assembly sets goals for itself which are designed to keep the legislature functioning smoothly. Some of those goals become impossible to fulfill, due to the amount and variety of legislation introduced. This year, however, the legislature outdid itself in keeping to its own deadlines, thereby accomplishing several remarkable firsts.

1. The legislature adjourned on time.
2. Most committees were able to keep to their own schedules and to accomplish everything they were supposed to in the time they were supposed to do it.
3. The even-numbered year session of the legislature is supposed to be limited to budgetary and revenue matters. With only a few exceptions that is precisely what the legislature limited itself to.

One of the most "notable exceptions" to this statement was the extensive debate on the Equal Rights Amendment. All other items were put on a back burner, pending the outcome of the ERA vote. As has been reported in every newspaper in the state, ERA was defeated, but only then was the legislature able to move rapidly through the remainder of its business.

A second "notable exception" was a proposal in which ISMS was vitally interested—the revision of the Mental Health Code. This package of bills resulted from almost four years of research, public hearings, and work by the Governor's Commission on the Revision of the Mental Health Code, established by Governor Walker. The bills were introduced in 1977 and were again the subject of weeks of additional study, modification, and hearing, which finally culminated in their passage on June 30, 1978.

The legislature is now adjourned until after the November elections, when they will reconvene to consider any Thompson vetoes.

The following is a list of major ISMS legislation and its status.

| BILL # | *SPONSOR* | *DESCRIPTION* | *STATUS AS OF 9-15-78* |
|---|---|---|---|
| HB 2339 | Tipsword<br>Berman | Hospital Rate Review Act<br>(See SB 1060) | Senate—Second Reading |
| HB 2418 | House Com.<br>on Revenue | Abolishes personal property tax; replaces revenues lost with new taxes on corporations, partnerships, associations, estates & trusts, etc. | In Senate Rules Committee |
| HB 2506 | House Human<br>Resources Com. | Reinstates permit physicians in mental health institutions. | Vetoed by the Governor on 7/3/78 |
| HB 2625 | Ebbesen<br>Grotberg | Permits M.D.'s to use cannabis to treat glaucoma or side effects of chemotherapy. | Signed 9-12-78 |
| HB 2794 | Yourell | Abolishes County Hospital Governing Commission—gives functions, powers & duties to University of Illinois. | House—Interim Study |
| HB 2878 | House Human<br>Resources Com. | Amends Comprehensive Health Planning Act. | Defeated in the House |
| HB 2883 | House Human<br>Resources Com. | Certificate of Need Legislation | House—Interim Study |
| HB 3059 | House Human<br>Resources Com. | Ambulance Service Act to license & regulate ambulances. | Defeated in House |
| HB 3097 | Winchester<br>Sangmeister | Amends Acts relating to the establishment & maintenance of health departments & public health districts. | Amendatory Veto<br>9-15-78 |
| HB 3125 | E. Barnes | Reduces line items in Public Aid budget—including medical assistance. | Held in House Committee |
| HB 3157 | Redmond<br>Leonard | Adds to list of grounds for revocation of medical vendor licenses by Dept. of R & E for violations under medical assistance program. | Amendatory Veto<br>9-11-78 |

| BILL # | *SPONSOR* | *DESCRIPTION* | *STATUS AS OF 9-15-78* |
|---|---|---|---|
| HB 3158 | Redmond | Creates Public Aid Fraud Investigation Unit within Dept. of Law Enforcement. | Defeated in the House |
| HB 3160 | Redmond Lane | Requires Public Aid recipient social security number be listed on vouchers. | Defeated on Senate Floor |
| HB 3161 | Redmond Leonard | Requires IDPA to report annually to General Assembly on proposed rate structure for medical vendors. | Amendatory Veto 8-18-78 |
| HB 3163 | Redmond | Requires all departments to act on any application within 90 days. | House—Interim Study |
| HB 3227 | Stiehl Schaffer | Allows use of physician license fee for expenses of Medical Examining Committee and to monitor CME. | Signed 6-30-78 |
| HB 3296 | Campbell Newhouse | Creates Long Term Care Peer Protection Act. | Signed 8-2-78 |
| HB 3399 | Polk | Amends Blood Bank Act removing requirement that blood bank director must be certified by American Board of Pathology. | In House Rules Committee |
| SB 250 | Netsch Sandquist | Creates new Mental Health Code. | Signed 9-5-78 |
| SB 252 | Nimrod Willer | Provides for guardian for adults who are developmentally disabled or mentally ill. | Signed 9-5-78 |
| SB 253 | Daley Beatty | Creates Human Rights Authority Act to "safeguard rights of persons receiving mental health or developmental disability services." | Signed 9-5-78 |
| SB 255 | Demuzio Mugalian | Provides all records of persons receiving mental health and developmental services are confidential and may be disclosed only as provided in this Act. | Amendatory Veto 9-5-78 |
| SB 1060 | Berman Tipsword | Hospital Rate Review Act (comparable to HB 2339). | Signed 8-7-78 |
| SB 1616 | Berning Deuster | Requires consent of parent or guardian of persons under 18 prior to administration of Laetrile. | Tabled. |
| SB 1760 | Newhouse Yourell | Increases size of Cook County Hospital Governing Commission. | Defeated on House Floor |
| SB 1761 | Newhouse Levin | Allows Cook County Hospital Governing Commission to be reimbursed for services to inmates of Cook County jail. | Passed Senate— In House Rules Committee |
| SB 1800 | Lane | Requires Public Aid recipient social security number be listed on vouchers (comparable to HB 3160). | Defeated in the Senate |
| SB 1822 | Leonard Chapman | Requires IDPA to file annual report with General Assembly re. provisions and use of medical services and proposed rate structures for medical providers (comparable to HB 3161). | Tabled in House Committee |
| SB 1827 | Graham Friedland | Establishes the Pre-Hospital Emergency Services Act. | Signed 7-27-78 |
| SB 1850 | D'Arco Kucharski | Reinstates psychiatric care under State Employee Group Insurance Act. | Vetoed by the Governor 8-23-78 |

NONPARTISAN

# IMPAC

**ILLINOIS MEDICAL POLITICAL ACTION COMMITTEE**
55 East Monroe Street
Chicago, Illinois 60603
312/782-1963

Dear Doctor:

I'm sure by now that most of you are aware of what IMPAC is, what it does, and how it works. I trust that this page has been helpful in broadening your understanding of IMPAC, as many of you have joined.

However, it is extremely disturbing that all of you and your spouses aren't members of organized medicine's most active political arm. The IMPAC Council believes that those of you who don't belong must want further information regarding IMAPC. To provide more information we have developed the brochure which immediately follows this letter. Once you've read it, we're sure you'll join those of us who fully comprehend the effects of politics on medicine.

I am concluding this letter with your IMPAC membership application. Please fill it out now. Then read the brochure. If you agree that IMPAC can help open important political doors, mail the application with your membership today. Join the thousands of physicians and their spouses who contribute to medicine's future.

Sincerely,

Herbert Sohn, M.D.

Herbert Sohn, M.D.
Chairman

---

**IMPAC/AMPAC Membership**
(check one)

☐ Sustaining, $99 ☐ Family, $45 ☐ Regular, $25 ☐ Auxiliary, $20

Return to:
IMPAC, 55 E. Monroe Street, Suite 3510, Chicago, Illinois 60630

**NAME** _____ **PHONE** _____

**ADDRESS** _____ **CITY** _____ **ZIP** _____

Contributions are not limited to the suggested amount. Neither the Illinois State Medical Society nor the AMA will favor or disadvantage anyone based upon the amounts of or failure to make pac contributions. Copies of IMPAC & AMPAC reports are filed with and are available for purchase from the Federal Election Commission, Washington, D.C. Contributions are subject to the limitations of FEC regulations, Sections 110.1, 110.2 & 110.5. (Federal regulations require this notice.) IMPAC reports are also filed with the State Board of Elections, and are or will be availat for purchase from the State Board of Elections, 1020 South Spring Street, Springfield, Illinois 62704.




**ISMS Delegation to the American Medical Association**

**AMA Delegation Report**

**Schedule of Meetings**

**Committees of the House of Delegates**

**Resolutions**

# Members of the 1978
## Interim Meeting
# House of Delegates

### OFFICERS

President .....David S. Fox
President-Elect .....P. John Seward
1st Vice President .....Herschel Browns
2nd Vice President .....G. W. Giebelhausen
Secretary-Treasurer .....Audley F. Connor, Jr.
Speaker of the House .....Cyril C. Wiggishoff
Vice Speaker .....Robert P. Johnson

### TRUSTEES

| | | | | | |
|---|---|---|---|---|---|
| First District | John J. Ring | 1980 | | Joseph Sherrick | 1980 |
| Second District | Allan L. Goslin | 1980 | Fourth District | Fred Z. White | 1979 |
| Third District | Alfred Clementi | 1979 | Fifth District | Paul F. Mahon | 1979 |
| | Raymond DesRosiers | 1980 | Sixth District | Robert R. Hartman | 1981 |
| | Robert T. Fox | 1979 | Seventh District | Alfred J. Kiessel | 1979 |
| | Jere E. Freidheim | 1979 | Eighth District | James Laidlaw | 1979 |
| | Morris T. Friedell | 1981 | Ninth District | Warren D. Tuttle | 1981 |
| | Henrietta Herbolsheimer | 1981 | Tenth District | Julian W. Buser | 1981 |
| | Lawrence L. Hirsch | 1981 | Eleventh District | Kenneth A. Hurst | 1980 |
| | Harold J. Lasky | 1980 | Twelfth District | Joseph Perez | 1980 |
| | Richard N. Rovner | 1980 | Trustee-at-Large | George T. Wilkins, Jr. | |

### Past Presidents

| | | | |
|---|---|---|---|
| J. Ernest Breed | 1971 | Fredric D. Lake | 1975 |
| Edward W. Cannady | 1970 | Willis I. Lewis | 1954 |
| Everett P. Coleman | 1945-46 | Burtis E. Montgomery | 1966 |
| Newton DuPuy | 1968 | Edward A. Piszczek | 1965 |
| Harlan English | 1964 | Caesar Portes | 1967 |
| Edwin S. Hamilton | 1962 | Willard C. Scrivner | 1974 |
| H. Close Hesseltine | 1961 | Joseph H. Skom | 1977 |
| J. M. Ingalls | 1976 | Leo P. A. Sweeney | 1953 |
| C. J. Jannings, III | 1972 | Philip G. Thomsen | 1969 |
| Frank J. Jirka, Jr. | 1973 | George T. Wilkins, Jr. | 1978 |

### Delegates to AMA

| | | |
|---|---|---|
| Herschel Browns | Jack L. Gibbs | John J. Ring |
| Allison Burdick, Jr. | Theodore Grevas | Joseph H. Skom |
| Howard C. Burkhead | Lawrence L. Hirsch | Fred A. Tworoger |
| David S. Fox | Morgan M. Meyer | Charles K. Wells |
| | Joseph R. O'Donnell | |

### Past Trustees or Councilors

| | | | |
|---|---|---|---|
| Earl H. Blair | Third District | William M. Lees | Third District |
| Joseph Bordenave | First District | A. Edward Livingston | Fifth District |
| Walter C. Bornemeier | Third District | Joseph R. O'Donnell | Eleventh District |
| Herbert Dexheimer | Tenth District | Mather Pfeiffenberger | Sixth District |
| Alfred Faber | Third District | Ralph N. Redmond | Second District |
| George E. Giffin | Second District | George Shropshear | Third District |
| Arthur F. Goodyear | Seventh District | Darrell H. Trumpe | Fifth District |
| Lee N. Hamm | Fifth District | Frederick E. Weiss | Third District |
| Eugene Hoban | Third District | Charles K. Wells | Ninth District |
| Ross Hutchison | Eleventh District | Herman Wing | Third District |
| Eugene P. Johnson | Eighth District | Warren Young | Third District |
| Ted LeBoy | Third District | Paul P. Youngberg | Fourth District |

# Delegates and Alternate Delegates to the Illinois State Medical Society

## DOWNSTATE DELEGATES

| *County* | *Delegates* | *Alternate* |
|---|---|---|
| Adams | Walter Stevenson, III | Marvin Grote |
| Alexander | Charles L. Yarbrough | Gemo Y. Wong |
| Bond | M. K. Kaufman | Boyd McCracken |
| Boone | M. Mijanovich | Earl Davis |
| Bureau | Louis D. Tarsinos | Louis Lukancic |
| Carroll | L. B. Hussey | C. G. Piper |
| Cass-Brown | | |
| Champaign (3) | Harold Kolb | Richard C. Adams |
| | Richard Helfrich | Michael Russo |
| | Frank Kresca | Harlan Failor |
| Christian | M. T. Salaymeh | |
| Clark | George T. Mitchell | Eugene P. Johnson |
| Clay | | |
| Clinton | Wilson L. DuComb | James A. Kirby |
| Coles-Cumberland | Mack W. Hollowell | Joseph Mallory |
| Crawford | Charles Salesman | T. P. Sloan |
| DeKalb | John W. Ovitz, Jr. | |
| DeWitt | S. Kolandaivelu | Robert E. Myers |
| Douglas | Humberto Mondul | Robert Arrol |
| DuPage (8) | Morgan M. Meyer | John V. Ryan |
| | James P. Campbell | Joseph P. McKay |
| | William C. Perkins | Neil S. Agruss |
| | William B. Frymark | Orren D. Baab |
| | Joseph R. O'Donnell | Robert D. Dooley |
| | Raymond A. Dieter | Vernon H. Bartley |
| | Thomas W. Stach | Ralph Ryan |
| | Ronald M. Severino | Harold G. Bicek |
| Edgar | J. M. Ingalls | J. R. Shackelford |
| Edwards | Andrew Krajec | Paul Nierenberg |
| Effingham | Robert Farmer | |
| Fayette | D. H. Rames | |
| Ford | Somchai Supawanich | Edson Etherton |
| Franklin | James Durham | |
| Fulton | Jack Gibbs | Rod Maguire |
| Gallatin | John E. Doyle | |
| Greene | James C. Reid | Jose Parcon |
| Hancock | Charles F. Eddingfield | Muhammed Hafeez |
| Henderson | Silvino C. Lindo | |
| Henry-Stark | Richard M. Terry | William D. Larson |
| Iroquois | R. K. Swedlund | J. E. Dailey |
| Jackson | Paul P. Lorenz | Eli L. Borkon |
| Jasper | | |
| Jefferson-Hamilton | James R. Heersma | H. Goff Thompson |
| Jersey-Calhoun | Bernard Baalman | Herman Wuestenfeld |
| Jo Daviess | Lyle A. Rachuy | |
| Kane (4) | A. Beaumont Johnson | James C. Pritchard |
| | Wayne Leimbach | Peter Starrett |
| | James A. McDonald | William Sheehy |
| | George Shimkus | |
| Kankakee | Donald Parkhurst | Richard Stoval |
| Kendall | Walter H. Brill | |
| Knox | Jerry Ramunis | Richard M. Flacco |
| Lake (5) | Arthur A. Woloshin | Gerald M. Goshgarian |
| | David S. Helberg | Richard K. Hawkins |
| | Earl V. Klaren | Homer Goldstein |
| | Eugene Pitts | Silverio Agujar |
| | Hugh Falls | James Creath |
| LaSalle | E. J. Fesco | Richard Schmidt |
| Lawrence | R. C. Kirkwood | Larry Herron |
| Lee | Donald Edwards | Kyu Jin Cho |
| Livingston | Karl T. Deterding | John C. Purnell |
| Logan | Glen E. Tomlinson | |
| Macon (2) | D. Statzer | C. O. Stanley |
| | J. Schrodt | |
| Macoupin | Robert G. England | J. K. Villigas |
| Madison (2) | E. K. DuVivier | Edward Ragsdale |
| | Melvin Freedman | Robert Hamilton |
| Marion | E. F. Stephens, III | W. P. Plassman |
| Mason | Jack Means | |
| Massac | | |
| McDonough | Samuel M. Gines | John S. Goncher |
| McHenry | August M. Rossetti | William Larsen |
| McLean (2) | Loren Boon | Wil Thielemann |
| | Robert Reardon | Robert Knight |
| Menard | | |
| Mercer | Monty P. McClellan | James W. Hastings |
| Monroe | E. F. Maglasang | |
| Montgomery | Lee Johnson | |
| Morgan-Scott | Frank Norbury | Thomas Wilson |
| Moultrie | | |
| Ogle | Don E. Hinderliter | Vincent Traina |
| Peoria (4) | Ernest F. Adams | John J. Taraska |
| | Gregory Spano | Dennis Garwacki |
| | Wilbert Newcomer | Ronald Kowalski |
| | Gene O. Hoerr | Thomas Cusack |
| Perry | C. E. Cawvey | B. A. Kinsman |
| Piatt | Wm. E. Mundt | George G. Green |
| Pike | Carlos B. Lara | Thomas C. Bunting |
| Pulaski | A. L. Robinson | |
| Randolph | O. W. Pflasterer | Stephen M. Platt |
| Richland | Charles A. DeKovessey | Michael E. Murray |
| Rock Island (3) | James F. Duesman | Manuel O. Guerrero |
| | Donald D. Tomlin | Richard D. Retz |
| | Richard Arnell | Phillip T. Siegert |
| St. Clair (3) | H. Frank Holman | Terrence G. Klingele |
| | Thomas P. Meirink | Michael G. Murphy |
| | Mays C. Maxwell | Charles C. Weiland |
| Saline-Pope-Hardin | A. Z. Goldstein | C. E. Seten |
| Sangamon (4) | Twofig M. Arjmand | Jess Diamond |
| | Edward G. Ference | David B. Lewis |
| | Robert L. Prentice | Michael Snyder |
| | Gerald T. Riordan | Richard Suhs |
| Schuyler | Henry C. Zingher | Robert E. Cox |
| Shelby | Theodore Little | Edwin J. Siroy |
| Stephenson | William H. Isham | F. H. Descourouez |
| Tazewell | Roger E. Neumann | Robert M. Wright |
| Union | Robert Rader | Wm. Whiting |
| Vermilion | W. F. Hensold | Grover W. Seitzinger |
| Wabash | R. L. Fuller | Wm. Walling |
| Warren | K. E. Ambrose | J. Marshall |
| Washington | J. L. Beguelin | |
| Wayne | C. J. Jannings, III | C. Loftin |
| White | Phillip Boren | |
| Whiteside | John Hubbard | Clarence Mueller |
| Will-Grundy (3) | Merle L. Otto | Kenneth M. Uznanski |
| | Guy A. Pandola | John D. Walter |
| | Robert J. Becker | Albert W. Ray, Jr. |
| Williamson | Herbert V. Fine | Renato Katubig |
| Winnebago (5) | Robert Behmer | R. Glenn Smith |
| | George C. Green | H. Clifford Carlson, Jr. |
| | Eugene T. Leonard | Raymond Hoffman |
| | F. H. Riordan, III | Ronald Ramstedt |
| | Richard C. Webb | |
| Woodford | Ronald Meyers | Robert Lykkebak |
| Students | David Aizuss | Jason Chao |
| Housestaff | James DeBord | Anthony Savino |

# Cook County Delegates

| *Delegates* | *Alternate Delegates* | *Delegates* | *Alternate Delegates* |
|---|---|---|---|
| Aaronson, Donald | Ahstrom, James, Jr. | Meisenheimer, Martin P. | Nainis, William S. |
| Ackley, William O. | Ashley, William F. | Moles, Joseph B. | Nikurs, Lydia |
| Andelman, Samuel L. | Banich, Francis E. | Murray, Meredith B. | Olivar, Adriano S. |
| Andersen, James H. | Banuchi, Fedor F. | Nemecek, Raymond W. | Olivieri, Ernest P. |
| Blankshain, Richard | Barber, Frederick | Neskodny, J. F. | O'Sullivan, Donal D. |
| Bogen, Gilbert | Bartolome, Juanito | Norberg, Clarence A. | Pemintuan, Rodolfo, L. |
| Brislen, Andrew J. | Beck, Charles A. | O'Brien, James C. | Panayotou, Irene |
| Brown, Finley W. Jr. | Berg, Max | Odiaga-Garcia, Ignacio | Pantone, Anton M. |
| Budrys, Stanley | Bild, Sidney | O'Donnell, John W. | Paull, Murry M. |
| Burkhead, Howard C. | Borden, Nicholas J. | Okner, Henry B. | Pedroso, Aldo F. |
| Chamberlain, Danford O. | Borelli, Nelson | Palumbo, Carl F. | Perritt, Richard A. |
| Ciskoski, Ronald J. | Branovacki, Eugene | Patlak, Erwin M. | Pill, Michael P. |
| Costanzo, Vincent A. | Burdick, Allison L., Jr. | Peterson, Arthur R. | Pleotis, Peter |
| Cross, Roland R. | Burdick, Allison L., Sr. | Petty, David T. | Poma, Pedro A. |
| Czeisler, Tibor | Burke, Edward A. | Quinlan, Donald | Prombo, Marjorie P. |
| DeYoung, Willard | Cermak, Miles | Razim, Edward A. | Pruc, Jeremias N. |
| Falloon, Edwin L. | Chaljub, Najib | Reeder, Clifton L. | Rebendel, Marek B. |
| Filipowicz, Roman I. | Christensen, Eldis M. | Rice, C. Malcolm Jr. | Rodriguez, Ignacio |
| Fischer, Arthur | Constantaras, Alexander | Romanus, Raymond J. | Rogin, Alan |
| Fish, William | De La Mata, Augustin | Rothstein, David A. | Rosenzweig, Oscar |
| FitzGibbons, James P. | De Rose, William F. | Sarley, Vincent C. | Rowlette, Raymond S. |
| Flanagan, C. Larkin | De Trana, Frank A. | Saxena, Virendra S. | Roy, Shirley |
| Frankel, Jerome J. | Diaz, Alfonso | Schimel, Samuel J. | Ruane, Michael |
| Freda, Vincent C. | Diffenbaugh, Willis G. | Sedlak, Frank | Saltiel, Isaac |
| Fredrick, Earl Jr. | Farah, George S. | Seed, Randolph W. | Schwartz, Franklin |
| Friefeld, Nathan | Forman, Max | Shapiro, Maynard I. | Schuetz, John N. |
| Gertz, George | Gardner, Philip M. | Shobris, Martin | Scruggs, Charles |
| Graham, James F. | Gau, Frederick | Sinaiko, Edwin S. | Seskind, Coleman R. |
| Green, Martin W. | Gilbert, Hugh | Smith, C. Otis | Singh, Nerissa P. |
| Guerrero, Severo K., Jr. | Gnade, Gerard R. | Smith, William | Spinka, Harold |
| Hamilton, Robert C. | Goodman, Harold | Soboroff, Burton J. | Springer, Harry A. |
| Harrod, John P., Jr. | Gross, Alvin | Solon, Earl N. | Stopka, John E. |
| Hinkamp, Joseph F. | Gurney, Clifford W. | Sperling, Richard L. | Strohl, Lee H. |
| Horton, Loren B. | Handler, Jerome L. | Staley, Warren H. | Surath, Vasanth M. |
| Hrejsa, Allen C. | Head, Louis | Suckow, Earl E. | Thampy, Kishore J. |
| Hussey, Frank L., Sr. | Hollett, Alan M. | Sugar, Sam J. | Thrasher, Irving D. |
| Hutchison, William A. | Hussey, Frank L., Jr. | Swartz, Robert M. | Tsatsos, George |
| Hyde, John S. | Jaffe, Harry J. | Talso, Peter J. | Ungar, Jacob |
| Jacobs, W. Francis | John, Thomas | Tansey, William J. | Urban, Conrad J. |
| Jirka, Frank J., Jr. | Jones, Richard | Thompson, J. Robert | Zitek, Russell W. |
| Joslyn, A. Everett, Jr. | Kass, Harold M. | Tovar, Jorge | |
| Kalsch, Harry E. | Kerr, William D. | Treister, Michael R. | |
| Kaz, Alex H. | Kobak, Mathew W. | Turner, George C. | |
| Kirschenbaum, M. Barry | Koch, Donald | Tworoger, Fred A. | |
| Kowal, Roland A. | Krolikowski, John R. | Walkowiak, Lydia | |
| Kozak, John A. | Landau, Richard L. | Waller, Jesse E. | |
| Kunis, Arthur | Lipsich, Michael | Weigel, Charles J. | |
| Kwinn, Frank C. | Lucina, Pedro A. | Weingarten, Charles Z. | |
| Lagorio, George L. | Mahlar, Sandra | Williams, Jack | |
| Lobraico, Rocco V., Jr. | McCabe, Mary Joan | Xydakis, Stephanos A. | |
| Lounsbury, B. Franklin | Mella, Luis | Yanez, Frank | |
| MacNerland, Robert H. | Mikhail, Kamel A. | Yatvin, Harold | |
| Marcus, Anna A. | Muehrcke, Robert C. | | |
| Markoutsas, George C. | Munoz, Maria | | |
| Marshall, William | Murphy, Thomas E. | | |
| Mehlinger, Kermit T. | Mustell, Robert R. | | |

# Officers of County Medical Societies
# 1978

| County | President | Secretary |
|---|---|---|
| Adams<br>Members: 93-Dist. 6<br>Maxine Boyer, Ex. Sec.<br>1118 Broadway<br>Quincy 62301 | Guenter Gehrich<br>1101 Maine, Quincy 62301 | Richard L. Newman<br>1124 Broadway, Quincy 62301 |
| Alexander<br>Members: 9-Dist. 9 | Gemo Wong<br>2020 Cedar, Cairo 62914 | Charles L. Yarbrough<br>800 Commercial, Cairo 62914 |
| Bond<br>Members: 9-Dist. 7 | M. Kenneth Kaufmann<br>105 E. College, Greenville 62246 | John K. Dawdy<br>404 Forest Lane, Greenville 62246 |
| Boone<br>Members: 20-Dist. 12 | Maurice J. Carlisle<br>115 W. Lincoln, Belvidere 61008 | John Steinkamp<br>824 S. Van Buren, Belvidere 61008 |
| Bureau<br>Members: 35-Dist. 2 | James Foresman<br>204 Park Ave., Princeton 61356 | Donald M. Gallagher<br>Box 538, Granville 61326 |
| Carroll<br>Members: 7-Dist. 12 | Basilios Lambos<br>North 4th Street, Savannah 61074 | Tadeusz Maciejczyk<br>Milledgeville 61051 |
| Cass-Brown<br>Members: 2-Dist. 6 | R. A. Spencer<br>115 W. 4th St., Beardstown 62618 | B. A. DeSulis<br>115 W. 4th St., Beardstown 62618 |
| Champaign<br>Members: 216-Dist. 8<br>Larry Booth, Ex. Sec.<br>1408 W. University<br>Urbana, 61801 | Richard B. Helfrich<br>602 W. University, Urbana 61801 | H. Ewing Wachter<br>2108 W. Springfield, Champaign 61820 |
| Christian<br>Members: 25-Dist. 7 | E. Doyle Slifer<br>201 E. Pleasant St., Taylorville 62568 | I. Del Valle<br>311 S. Main, Taylorville 62568 |
| Clark<br>Members: 7-Dist. 8 | Howard G. Johnson<br>Casey Medical Center, Casey 62420 | Eugene P. Johnson<br>P.O. Box 68, Casey 62420 |
| Clay<br>Members: 7-Dist. 7 | A. Paul Naney<br>Flora Clinic, Flora 62839 | Donald L. Bunnell<br>Flora Clinic, Flora 62839 |
| Clinton<br>Members: 11-Dist. 7 | James A. Kirby<br>401 N. Main, Breese 62230 | Robert D. Roane<br>1131 Fairfax St., Carlyle 62231 |
| Coles-Cumberland<br>Members: 44-Dist. 8 | H. C. Lin<br>1700 Wabash Ave., Mattoon 61938 | Asit P. Basu<br>501 Jackson Ave., Charleston 61920 |
| Cook<br>Members: 8570-Dist. 3<br>Robert Lindley, Ex. Adm.<br>310 S. Michigan Ave.<br>Chicago 60604 | Clifton L. Reeder<br>734 N. Merrill, Park Ridge 60068 | B. Franklin Lounsbury<br>927 Jackson, River Forest 60305 |
| Crawford<br>Members: 15-Dist. 8 | Thomas P. Sloan<br>Schmidt Clinic, Robinson 62454 | W. B. Schmidt<br>Schmidt Clinic, Robinson 62454 |
| De Kalb<br>Members: 58-Dist. 12 | Stanley D. Brandon<br>Kishwaukee Prof. Bldg., Rt. 23 &<br>Bethany Rd., Box 746, DeKalb 60115 | Loren W. Akers<br>Northern Ill. Univ., DeKalb 60115 |
| De Witt<br>Members: 11-Dist. 5 | John W. Veirs<br>219 E. Main, Clinton 61727 | C. N. Radhakrishna<br>210 E. Main, Clinton 61727 |
| Douglas<br>Members: 8-Dist. 8 | Walter Steiner<br>140 W. Sale Street, Tuscola 61953 | Humberto Mondul<br>111 W. South Central, Tuscola 61953 |
| Du Page<br>Members: 595-Dist. 11<br>Lillian Widmer, Ex. Sec.<br>26 W. St. Charles Rd.<br>Lombard, IL 60148 | Thomas W. Stach<br>120 Oakbrook Center Mall,<br>Oak Brook 60521 | James P. Campbell<br>322 N. Blanchard St., Wheaton 60187 |

| County | President | Secretary |
|---|---|---|
| Edgar<br>Members: 17-Dist. 8 | J. R. Shackelford<br>502 Shaw, Paris 61944 | J. M. Ingalls<br>Medical Center Clinic, Paris 61944 |
| Edwards<br>Members: 3-Dist. 9 | Paul S. Neirenberg<br>7 W. Main, Albion 62806 | Andrew Krajec<br>108 W. South St., West Salem 62476 |
| Effingham<br>Members: 23-Dist. 7 | Yong Lee<br>602 Park Hills, Effingham 62401 | Fabio H. Mota<br>300 N. Maple, Effingham 62401 |
| Fayette<br>Members: 7-Dist. 7 | Joshua Weiner<br>1007 N. Eighth St., Vandalia 62471 | Vasudev Kachgal<br>802 N. Eighth St., Vandalia 62471 |
| Ford<br>Members: 13-Dist. 11 | William A. Garrett<br>Sibley 61773 | Paul W. Sunderland<br>214 N. Sangamon, Gibson City 60936 |
| Franklin<br>Members: 29-Dist. 9 | James P. Durham<br>Benton Med. Clinic, Benton 62812 | D. P. Richerson<br>P.O. Box 99, Christopher 62822 |
| Fulton<br>Members: 31-Dist. 4 | Marvin E. Schmidt<br>Graham Hospital, 210 W. Walnut,<br>Canton 61520 | Marcos A. Arancibia<br>Graham Hospital<br>210 W. Walnut, Canton 61520 |
| Gallatin<br>Members: 2-Dist. 9 | | John E. Doyle<br>Ridgway 62979 |
| Greene<br>Members: 6-Dist. 6 | Jude A. Caselton<br>9th St., Carrollton 62016 | James C. Reid<br>Fillager Mem. Clinic, Greenfield 62044 |
| Hancock<br>Members: 12-Dist. 4 | Vasant Pawar<br>Memorial Hospital, Carthage 62321 | James E. Coeur<br>630 Locust, Carthage 62321 |
| Henderson<br>Members: 1-Dist. 4 | Silvino Lindo, Jr.<br>Biggsville 61418 | |
| Henry-Stark<br>Members: 37-Dist. 4 | Roberto S. Puentes<br>100 E. Main, Geneseo 61254 | Donald R. Ford<br>648 N. Chicago St., Geneseo 61254 |
| Iroquois<br>Members: 19-Dist. 11 | | Y. S. Song<br>P.O. Box V348, Watseka 60970 |
| Jackson<br>Members: 61-Dist. 9 | Roger N. Klam<br>Box 2347, Carbondale 62901 | Steven A. Nagel<br>404 W. Main Street, Carbondale 62901 |
| Jasper<br>Members: 2-Dist. 8 | Don L. Hartrich<br>1211 W. Jourdan, Newton 62448 | Monico Low<br>609 S. Van Buren, Newton 62448 |
| Jefferson-Hamilton<br>Members: 34-Dist. 9 | Prince B. Oliver<br>Post Office Box 1001, Mt. Vernon 62864 | Kenneth A. Peart<br>Doctors Park, Mt. Vernon 62864 |
| Jersey-Calhoun<br>Members:12-Dist. 6 | S. S. Kurella<br>McDow Med. Cntr., Maple Summit Rd.,<br>Jerseyville 62052 | Bernard Baalman<br>Medical Center, Hardin 62047 |
| Jo Daviess<br>Members: 8-Dist. 12 | William Gillies<br>300 Summit St., Galena 61036 | David Hockman<br>300 Summit St., Galena 61036 |
| Kane<br>Members: 307-Dist. 1<br>Michael Wild, Ex. Dir.<br>202 Campbell<br>Geneva 60134 | Charles K. Bobelis<br>860 Summit, Elgin 60120 | James R. Downing<br>157 S. Lincoln, Aurora 60505 |
| Kankakee<br>Members: 103-Dist. 11 | Morris Lang<br>1309 E. Court St., Kankakee 60901 | Charles F. Lind<br>500 W. Court St., Kankakee 60901 |
| Kendall<br>Members: 7-Dist. 11 | Walter Brill<br>Main St., Oswego 60543 | John P. Cullinan<br>Oswego 60543 |
| Knox<br>Members: 74-Dist. 4 | Robert G. Hickerson, Jr.<br>309 E. Main, Knoxville 61448 | J. John Loesch<br>Galesburg Cottage Hosp., Galesburg 61401 |
| Lake<br>Members: 364-Dist. 1<br>Julia Schulz, Ex. Sec.<br>P.O. Box 148<br>Gurnee, Ill. 60031 | Joseph L. Burke<br>2504 Washington St., Waukegan 60085 | James R. Creath<br>2504 Washington St., Waukegan 60085 |

| County | President | Secretary |
|---|---|---|
| LaSalle<br>Members: 110-Dist. 2 | Mavis Schraudenbach<br>24 Stacy, Streator 61364 | Allan L. Goslin<br>712 N. Bloomington, Streator 61364 |
| Lawrence<br>Members: 9-Dist. 8<br>Ruth Gariepy, Ex. Sec.<br>Lawrence Cty. Mem. Hosp.<br>Lawrenceville 62439 | Robert J. Nichols<br>P.O. Box 907, Vincennes, Ind. 47591 | Alexander Po<br>R.R. #2, Lawrenceville 62439 |
| Lee<br>Members: 29-Dist.12 | George S. Silvest<br>White Oaks, R.R. 3, Dixon 61021 | Tiam H. Lie<br>Castellan, R.R. 5, Dixon 61021 |
| Livingston<br>Members: 29-Dist. 2 | Roger K. Kipfer<br>109 W. Howard St., Pontiac 61764 | Karl T. Deterding<br>612 E. Water, Pontiac 61764 |
| Logan<br>Members: 26-Dist. 5 | Glen Tomlinson<br>#4 Doctor's Park, Lincoln 62656 | Robert B. Perry<br>523 N. Elm, Lincoln 62656 |
| Macon<br>Members: 157-Dist. 7<br>Mary J. Bretz, Ex. Sec.<br>1800 E. Lake Shore Dr.<br>Decatur 62521 | Paul R. Stanley<br>418 W. Wood, Decatur 62522 | Joseph Schrodt<br>363 S. Main, Decatur 62523 |
| Macoupin<br>Members: 21-Dist. 6 | Jose K. Villegas<br>Physicians Bldg., Carlinville 62626 | Robert England<br>224 E. Main, Carlinville 62626 |
| Madison<br>Members: 178-Dist. 6 | Melvin Freedman<br>2025 Edison Ave., Granite City 62040 | Norman E. Taylor<br>95 S. 9th St., E. Alton 62024 |
| Marion<br>Members: 39-Dist. 7 | Hahmid Mahmud<br>111 E. Rogers, Salem 62881 | W. P. Plassman<br>Box 552, Centralia 62801 |
| Mason<br>Members: 6-Dist. 5 | Henry W. Maxfield<br>315 E. Chestnut, Mason City 62664 | |
| Massac<br>Members 3-Dist. 9 | Jack D. Diles<br>Massac Mem. Hosp., Metropolis 62960 | Benito Bajuyo<br>P.O. Box 187, Metropolis 62960 |
| McDonough<br>Members: 35-Dist. 4 | Kenneth T. Pawlias<br>501 E. Grant, Macomb 61455 | David Reem<br>505 E. Grant, Macomb 61455 |
| McHenry<br>Members: 82-Dist. 1<br>Evelyn Rosulek, Ex. Sec.<br>308 E. Kimball<br>Woodstock 60098 | Aniceto M. D'Sousa<br>1110 Green St., McHenry 60050 | Ted L. Rolander<br>1110 N. Green St., McHenry 60050 |
| McLean<br>Members: 116-Dist. 5<br>Bernyce Carbery<br>Exec. Sec.<br>401 W. Virginia<br>Normal 61761 | Hans Stroink<br>900 Franklin, Normal 61761 | Douglas R. Bey<br>900 Franklin Ave., Normal 61761 |
| Mercer<br>Members: 6-Dist. 4 | Monty P. McClellan<br>309 NW 2nd St., Aledo 61231 | |
| Monroe<br>Members: 9-Dist. 10 | Edilberto F. Maglasang<br>109 W. Legion, Columbia 62236 | Chung H. Khan<br>Route 1, Maeystown Rd., Waterloo 62298 |
| Montgomery<br>Members: 22-Dist. 5 | Calixto F. Aquino, Jr.<br>112 W. Kirkham St., Litchfield 62056 | James T. Foster<br>8 Arrowhead Rd., Litchfield 62056 |
| Morgan-Scott<br>Members: 48-Dist. 6 | A. George Schultz<br>2000 W. Morton, Jacksonville 62650 | James Veenstra<br>Passavant Memorial Hospital<br>1600 W. Walnut St., Jacksonville 62650 |
| Moultrie<br>Members: 5-Dist.-7 | Phillip Best<br>14 N. Washington, Sullivan 61951 | Dean McLaughlin<br>112 E. Harrison, Sullivan 61951 |

| County | President | Secretary |
|---|---|---|
| Ogle<br>Members: 15-Dist. 12 | L. T. Koritz<br>324 Lincoln, Rochelle 61068 | Russell Zack<br>915 Caron, Rochelle 61068 |
| Peoria<br>Members: 332-Dist. 4<br>M. John Hanni, Jr., Ex. Sec.<br>427 1st National Bank<br>Peoria 61602 | Lorris Bowers<br>427 1st Nat'l. Bank Bldg., Peoria 61602 | Henry Boldt<br>427 1st Nat'l. Bank Bldg., Peoria 61602 |
| Perry<br>Members: 15-Dist. 10 | Gene Stotlar<br>13 N. Walnut St., Pinckneyville 62274 | Bill R. Fulk<br>207 E. Main, DuQuoin 62832 |
| Piatt<br>Members: 5-Dist. 7 | George Green<br>121 N. State, Monticello 61856 | Joseph Allman<br>121 N. State, Monticello 61856 |
| Pike<br>Members: 10-Dist. 6 | Ansar H. Ansari<br>203 N. Madison, Pittsfield 62363 | T. C. Bunting<br>321 W. Washington, Pittsfield 62363 |
| Pulaski<br>Members: 1-Dist. 9 | A. L. Robinson<br>Box 277, Mounds 62964 | |
| Randolph<br>Members: 21-Dist. 10 | Teera Pittayathikhun<br>818 E. Broadway, Sparta 62286 | C. S. Schlageter<br>818 E. Broadway, Sparta 62286 |
| Richland<br>Members: 25-Dist. 8 | Michael E. Murray<br>1200 N. East, Olney 62450 | Peter C. Weber<br>1200 N. East, Olney 62450 |
| Rock Island<br>Members: 204-Dist. 4<br>James A. Koch, Ex. Sec.<br>612 Kahl Bldg.<br>Davenport, Iowa 52801 | James P. Johnston<br>1630 5th Ave., Moline 61265 | E. D. Lardner<br>3637 23rd Ave., Moline 61265 |
| St. Clair<br>Members: 250-Dist. 10<br>Ed Belz, Ex. Sec.<br>4825 W. Main<br>Belleville 62223 | Donald L. Jerome<br>6401 W. Main, Belleville 62223 | Paul Rusnack<br>St. Elizabeth's Hosp., Belleville 62220 |
| Saline-Pope-Hardin<br>Members: 33-Dist. 9 | H. Andrew Cserny<br>1405 Locust, Eldorado 62930 | Warren R. Dammers<br>P.O. Box 281, Harrisburg 62946 |
| Sangamon<br>Members: 313-Dist. 5<br>L. R. Brosi, Ex. Dir.<br>1 N. Old State Capitol<br>Plaza,<br>Springfield 62701 | Edward G. Ference<br>932 S. 2nd St., Springfield 62704 | Towfig Arjmand<br>1209 S. Fourth, Springfield 62704 |
| Schuyler<br>Members: 4-Dist. 4 | R. R. Dohner<br>103 W. Washington, Rushville 62681 | Henry C. Zingher<br>West Side Square, Rushville 62681 |
| Shelby<br>Members: 8-Dist. 7 | Theodore Little<br>207 S. Pine, Shelbyville 62565 | Otto G. Kauder<br>P.O. Box 225, Shelbyville 62565 |
| Stephenson<br>Members: 51-Dist. 12 | Edward Maglietta<br>1036 W. Stephenson, Freeport 61032 | Karl Schwiesow<br>220 W. Exchange, Freeport 61032 |
| Tazewell<br>Members: 53-Dist. 5<br>Colleen Ingersoll,<br>Exec. Sec.<br>P.O. Box 778<br>Pekin 61554 | Robert L. Tucker<br>P.O. Box 778, Pekin 61554 | Daniel L. Parr<br>P.O. Box 778, Pekin 61554 |
| Union<br>Members: 10-Dist. 9 | Robert L. Rader<br>200 N. Main St., Anna 62906 | William H. Whiting<br>525 N. Main, P.O. Drawer 559, Anna 62906 |
| Vermilion<br>Members: 97-Dist. 8 | Edmund G. Andracki<br>120 S. Main, Georgetown 61846 | L. W. Tanner<br>7 N. Virginia, Danville 61832 |
| Wabash<br>Members: 6-Dist. 9 | T. R. Young<br>512 Market St., Mt. Carmel 62863 | C. L. Johns<br>114 W. 5th St., Mt. Carmel 62863 |

| County | President | Secretary |
|---|---|---|
| Warren<br>Members: 13-Dist. 4 | James Marshall<br>319 N. Main, Monmouth 61462 | Glenn W. Chamberlin<br>219 E. Euclid, Monmouth 61462 |
| Washington<br>Members: 6-Dist. 10 | Charles Longwell<br>111 S. Washington, Nashville 62263 | Jerry L. Beguelin<br>Box 197, Irvington 62848 |
| Wayne<br>Members: 7-Dist. 9 | S. W. Konarski<br>101 E. Center, Fairfield 62837 | E. Loftin<br>301 N.W. 11th, Fairfield 62837 |
| White<br>Members: 8-Dist. 9 | William Courtnage<br>Carmi Med. Cntr., Carmi 62821 | Morris McCall<br>South Plum St., Carmi 62821 |
| Whiteside<br>Members: 50-Dist. 12 | Timothy Sullivan, Jr.<br>1716 Locust, Sterling 61081 | Roger Hill<br>101 E. Miller Rd., Sterling 61081 |
| Will-Grundy<br>Members: 232-Dist. 11<br>Ronald W. Batozech, Ex. Sec.<br>3033 W. Jefferson<br>Suite 220<br>Joliet 60435 | Archibald D. McCoy<br>57 W. Jefferson, Joliet 60431 | Robert L. Kleinhoffer<br>1415 Maple Rd., Joliet 60432 |
| Williamson<br>Members: 35-Dist. 9 | David L. Sloan<br>Herrin Hosp., Herrin 62948 | Herbert V. Fine<br>110 N. Division, Carterville 62918 |
| Winnebago<br>Members: 389-Dist. 12<br>Mrs. Johanna Lund<br>Exec. Adm.<br>310 N. Wyman St.<br>Rockford 61101 | George C. Green<br>4120 Charles St., Rockford 61108 | Bernard O'Malley<br>5670 E. State St., Rockford 61108 |
| Woodford<br>Members: 7-Dist. 2 | K. Vaicius<br>511 Oak, Minonk 61760 | James W. Riley<br>109 S. Major, Eureka 61530 |

**No Organized County Society**

Johnson
Marshall
Menard
Putnam

**Joint County Societies**

Cass-Brown
Coles-Cumberland
Henry-Stark
Jefferson-Hamilton
Jersey-Calhoun
Morgan-Scott
Saline-Pope-Hardin
Will-Grundy

# ISMS DELEGATION TO THE AMA

## Delegates

*To Serve from Jan. 1, 1977 to Dec. 31, 1978*
*(Elected April 28, 1976)*

Allison L. Burdick, Jr., Chicago
Alfred J. Faber, Chicago
David S. Fox, Chicago
Lawrence L. Hirsch, Chicago
Joseph R. O'Donnell, Glen Ellyn
John J. Ring, Mundelein
Charles K. Wells, Mt. Vernon

*To Serve from Jan. 1, 1978 to Dec. 31, 1979*
*(Elected April 27, 1977)*

Herschel Browns, Chicago
Howard C. Burkhead, Evanston
Jack Gibbs, Canton
Theodore Grevas, Rock Island
Morgan M. Meyer, Lombard
Joseph Skom, Chicago
Fred A. Tworoger, Chicago

*To serve from Jan. 1, 1979 to Dec. 31, 1980*
*(Elected April 5, 1978)*

Allison L. Burdick, Jr., Chicago
Alfred J. Faber, Chicago (resigned)
David S. Fox, Chicago
Lawrence L. Hirsch, Chicago
Joseph R. O'Donnell, Glen Ellyn
John Ring, Mundelein
Charles K. Wells, Mt. Vernon

### *Honorary Delegates*

Walter C. Bornemeier, Saratoga, Cal.
Edwin S. Hamilton, Kankakee
Frank J. Jirka, Jr., Barrington Hills
Burtis E. Montgomery, Harrisburg

*Delegation Chairman: Jack L. Gibbs; Secretary: Herschel Browns*

## Alternate Delegates

*To serve from Jan. 1, 1977 to Dec. 31, 1978*
*(Elected April 28, 1976)*

Andrew J. Brislen, Chicago[1]
Audley F. Connor, Jr., Chicago[2]
Morris T. Friedell, Chicago[3]
Henrietta Herbolsheimer, Chicago
Robert P. Johnson, Springfield
Eugene T. Leonard, Rockford
Andrew Thomson, Jr., Evanston[4]

*To serve from Jan. 1, 1978 to Dec. 31, 1979*
*(Elected April 27, 1977)*

Robert R. Hartman, Jacksonville
Eugene P. Johnson, Casey
Lee Johnson, Litchfield
Maynard I. Shapiro, Chicago
Andrew Thomson, Jr., Evanston
Glen E. Tomlinson, Lincoln
Cyril C. Wiggishoff, Chicago
George T. Wilkins, Granite City

*To serve from Jan. 1, 1979 to Dec. 31, 1980*
*(Elected April 5, 1978)*

Andrew J. Brislen, Chicago
Audley F. Connor, Jr., Chicago
Morris T. Friedell, Chicago
Henrietta Herbolsheimer, Chicago
Robert P. Johnson, Springfield
Eugene T. Leonard, Rockford

---

[1]Elected to fill unexpired term of Fredric D. Lake
[2]Elected to fill unexpired term of Joseph H. Skom
[3]Elected to fill unexpired term of Charles Schlageter
[4]Elected to fill unexpired term of Allison Burdick, Jr.

## Special Report

# Illinois Delegation To the American Medical Association Report to the House of Delegates

The Illinois Delegation introduced 11 resolutions at the 1979 annual meeting of the AMA House of Delegates June 18-22 in St. Louis. Following is the action taken on these resolutions:

*Resolution 109—Unfairness of Public Law 94-484, Title VI.* The following substitute was adopted:

That the American Medical Association strongly urge the Secretary, Department of Health, Education, and Welfare, to recognize examinations given by the Education Commission for Foreign Medical Graduates (ECFMG) and the Federation Licensing Examination (FLEX) of the Federation of State Medical Boards, Inc., and/or State Board Licensure exam, as equivalent to the Visa Qualifying Examination of the National Board of Medical Examiners for purposes limited to provisions of PL 94-484 for those alien FMGs who have approved or have applied for third preference petitions and possess a valid license to practice medicine in a licensing jurisdiction of the United States prior to January 10, 1977; and

That the Board of Trustees study the effects on alien foreign medical graduates and on U.S. institutions providing programs of graduate medical education, of the two-year limit for graduate medical education imposed by PL 94-484 on alien physicians who are temporary residents of the United States (holders of "J" visas) and report to the House of Delegates at the 1979 annual meeting.

*Resolution 110—Proposed Changes in Public Law 93-641, Reducing Number of Physicians on HSA Boards.* This resolution was amended and adopted as follows:

That the American Medical Association attempt to increase the number of physicians on Health Systems Agency Boards; and

That the American Medical Association contact all Congressmen for the purpose of having them support such changes in PL 93-641.

*Resolution 111—Proposed Changes in Public Law 93-641, Extending Certificate of Need Legislation.* The House adopted the following in lieu of six similar resolutions:

That the American Medical Association reaffirm its opposition to the extension of Certificate of Need at all levels of government to private physicians' offices; and

That the American Medical Association continue its opposition to the objectionable provisions of HR 10460 and S 2410; and

That the American Medical Association be commended for its efforts to remove the certificate of need and the decertification sections from HR 10460 and S 2410; and

That the AMA, with the assistance of state associations and county medical societies, inform their Congressmen and Senators of our determined opposition to these proposed intrusions by the federal government into the private practice of medicine.

*Resolution 112—Proposed National Guidelines for Health Planning by Department of HEW.* The House adopted this resolution, which called upon the AMA to request of the Department of Health, Education, and Welfare that, when a guideline discussion is presented in the "Federal Register," the source of the information being presented should be specifically identified.

*Resolution 113—Economic Impact Analysis and the Cost of Medical Care Summary Report.* The House adopted this resolution, which requested the AMA to seek appropriate legislation to incorporate the economic impact of regulations promulgated by the Department of Health, Education, and Welfare into recommendations for controlling the cost of medical care.

*Resolution 114—Key Man Program.* This resolution, which called upon the AMA to increase

its present efforts to develop an effective key man program, was referred to the Board of Trustees for report at the 1978 interim meeting. At the same time, the House adopted Report Y of the Board of Trustees, which informed the House of the activities the AMA has undertaken to increase and improve the legislative liaison between the AMA and state medical associations.

*Resolution 115—Optometric Services in VA Hospitals.* The House referred to the Board of Trustees this resolution which directs the AMA to support the concept that optometric services in all Veterans Administration facilities be directly responsible to their respective departments of ophthalmology and that the AMA communicate this position to the VA Chief Medical Director, and calls for repeal of that section of PL 94-581, Veterans Omnibus Health Care Act of 1976, authorizing creation of separate optometic services.

*Resolution 116—Rasic Courses in Nutrition.* The following substitute was adopted:

> That the American Medical Association encourage effective education in nutrition at the undergraduate, graduate and postgraduate levels.

*Resolution 117—Amendments to HR 1818.* This was referred to the Board of Trustees—with four similar resolutions—with instructions to determine if a new or substitute bill for HR 1818, Comprehensive Health Insurance Act of 1977, is necessary or not; and, if an AMA-sponsored National Health Insurance Bill is to be submitted at the Interim Meeting, it should be circulated to the members of the House of Delegates as early as possible so it may be studied in detail before that session.

*Resolution 118—Extending Preferential Treatment to HMOs and Discriminating Against Private Practice.* This resolution opposed any efforts to give preferential treatment to HMOs, especially under certificate of need and health planning laws. It was considered together with another similar resolution and with the Board of Trustees response to Recommendation No. 3 of the National Commission on the Cost of Medical Care. The House adopted the following statement in lieu of all three items:

> Approval of the concept of neutral public policy and fair market competition among all systems of health care delivery.

It referred to the Board of Trustees the recommendation that it seek an objective assessment of HMOs, including IPAs and other group arrangements, with respect to their impact on access, quality, and cost of health care.

*Resolution 119—Blue Cross/Blue Shield Rider.* The following substitute was adopted:

> That the American Medical Association urge all health insurance carriers and government health care financing agencies to rely on appropriate medical peer review programs for adjudication and resolution of all matters concerning the quality or utilization of medical services which require professional judgment; and
>
> That peer review programs shall have as their goal both improved quality of medical care and more efficient delivery of medical services.

The House also took the following action on two resolutions introduced by Dr. David S. Fox:

*Resolution 120—Confidentiality of PSRO Records.* Adopted this resolution requesting AMA to seek legislation that would exempt PSROs from the Freedom of Information Act.

*Resolution 121—Proposed Revision of Section 9, Principles of Medical Ethics.* Referred this resolution, along with several other resolutions and reports of the Judicial Council and Board of Trustees, to a special ad hoc committee on the Principles of Medical Ethics. Dr. Henrietta Herbolsheimer was appointed a member of this committee.

All members of the delegation were present for the meeting in St. Louis, except Dr. Alfred Faber and Dr. Morris T. Friedell. Dr. Herbolsheimer was seated for Dr. Faber and Dr. Robert C. Hamilton received credentials as an alternate delegate. The Delegation has regretfully received Dr. Faber's resignation.

The delegation met on the Saturday and Sunday preceding the opening session of the House of Delegates, interviewing some 30 or more candidates for AMA office or positions on AMA councils. During the week, the delegation met every morning for breakfast to review contents of the Delegates Handbook and reference committee reports.

One of this year's candidates was Illinois' Dr. Robert P. Johnson, who was unsuccessful in his campaign for election to the Council on Scientific Affairs.

Three members of the delegation served on reference committees: Dr. Morgan M. Meyer, chairman of Reference Committee B; Dr. Allison Burdick, Jr., a member of Reference Committee F, and Dr. Fred A. Tworoger, a member of Committee G. Dr. Joseph Skom served as a member of the Committee on Rules and Order of Business.

Jack Gibbs, M.D. *Chairman*

Herschel Browns, M.D. *Secretary*

ILLINOIS STATE MEDICAL SOCIETY

# SCHEDULE OF MEETINGS

## INTERIM HOUSE OF DELEGATES

**November 4-5, 1978**

**Wagon Wheel Lodge**
**Rockton, Illinois**

### Friday, November 3, 1978

| | |
|---|---|
| 9:30 a.m. | Board of Trustees Meeting |
| 12:00 noon | Board of Trustees Luncheon |
| 5:30 p.m. | Board of Trustees Reception and Dinner |
| 7:30 p.m. | Board of Trustees Meeting |

### Saturday, November 4, 1978

| | |
|---|---|
| 7:30 a.m. | Board of Trustees Breakfast |
| 9:30 a.m. | ISMIE Board of Governors Meeting |
| 9:30 a.m. | Delegates Registration Opens |
| 10:00 a.m. | Meeting of Reference Committee Personnel |
| 11:00 a.m. | Delegates Check-in with Credentials Committee |
| 12:00 noon | House of Delegates Meeting |
| 1:30 p.m. | District Caucuses |
| 2:30 p.m. | Reference Committee Meetings |
| 5:30 p.m. | Exchange of Ideas on Cost Containment<br>*(With Hon. Edward R. Madigan, Member of Congress)* |

### Sunday, November 5, 1978

| | |
|---|---|
| 7:30 a.m. | Board of Trustees Breakfast |
| 8:30 a.m. | District Caucuses |
| 9:00 a.m. | Delegates Check-in with Credentials Committee |
| 9:30 a.m. | House of Delegates Meeting |

# Committees of the House of Delegates

# 1978 Interim Meeting

## COMMITTEE ON RULES & ORDER OF BUSINESS

Charles J. Weigel, *Chairman* (CMS)

This committee shall consider all matters regarding rules governing actions, methods and procedure, and the order of business (agenda) for the session of the House of Delegates. It shall work in close cooperation with the Speaker and Vice Speaker.

Resolutions submitted after the deadline for receiving resolutions (four weeks prior to the annual or interim meeting) must be approved by the Committee on Rules and Order of Business, or by a two-thirds vote of the House, before they will be considered as business of the House of Delegates.

The committee shall contact the Speaker just prior to each session of the House to make sure that all recommendations for House action are included in its report.

## COMMITTEE ON CREDENTIALS

B. Franklin Lounsbury, *Co-Chairman* (CMS)
William C. Perkins, *Co-Chairman* (DS)

This committee shall consider all questions regarding the registration and certification of delegates. The chairman shall keep the Speaker of the House informed of the voting power thereof.

The committee shall distribute and receive the attendance slips and perform such other duties as may be assigned by the Speaker.

This committee shall meet at least one hour prior to the opening session of the House and one-half hour prior to the opening of the other sessions.

## TELLERS AND SERGEANTS AT ARMS

Lee Johnson, *Chief Teller* (DS)

This committee shall serve the Speaker of the House of Delegates whenever a vote count is called for, whenever a ballot is scheduled, or the House goes into executive session.

## REFERENCE COMMITTEE ON AMENDMENTS TO CONSTITUTION & BYLAWS

Robert C. Hamilton, *Chairman* (CMS)

This committee shall consider and report to the House of Delegates its recommendations on all proposed amendments to the Constitution and Bylaws.

## REFERENCE COMMITTEE A

Charles F. Eddingfield, *Chairman* (DS)

This committee shall consider and submit its recommendations to the House of Delegates upon resolutions relating to officers, administration, finances, budgets, economics and peer review.

## REFERENCE COMMITTEE B

Joseph B. Moles, *Chairman* (CMS)

This committee shall consider and submit its recommendations to the House of Delegates upon resolutions and reports relating to government health programs and planning.

## REFERENCE COMMITTEE C

J. M. Ingalls, *Chairman* (DS)

This committee shall consider and submit its recommendations to the House of Delegates upon resolutions relating to medical service, scientific matters, education and membership services.

## REFERENCE COMMITTEE D

William J. Tansey, *Chairman* (CMS)

This committee shall consider and submit its recommendations to the House of Delegates upon resolutions relating to governmental affairs, medical-legal, and public relations matters.

# Resolutions
# November, 1978 Interim Meeting
# House of Delegates

| *Number* | *Subject* | *Introduced By:* |
|---|---|---|
| 78N-1 | Medical School Admissions and Physician Shortage Areas | M. Barry Kirschenbaum, M.D. |
| 78N-2 | Government Influence on Cost of Medical Care | M. Barry Kirschenbaum, M.D. |
| 78N-3 | Revision in Policy Statement on Professional Liability | Lawrence L. Hirsch, M.D. for the Board of Trustees |
| 78N-4 | Deletion of Policy Statement on Medical Representation in Government Planning | Lawrence L. Hirsch, M.D. for the Board of Trustees |
| 78N-5 | Revision of Policy on Committee Appointments | Lawrence L. Hirsch, M.D. for the Board of Trustees |
| 78N-6 | Deletion of Administrative Policies—Education, Primary and Secondary; Facility Medical Boards (Physicians); and Federal Funds—from the Policy Manual | Lawrence L. Hirsch, M.D. for the Board of Trustees |
| 78N-7 | Revision of Policy Statement on Specialty Society Representation on ISMS Councils | Lawrence L. Hirsch, M.D. for the Board of Trustees |
| 78N-8 | Deletion of Relative Value Statement from Policy Manual | Lawrence L. Hirsch, M.D. for the Board of Trustees |
| 78N-9 | Revision of Public Aid Statement in Policy Manual | Lawrence L. Hirsch, M.D. for the Board of Trustees |
| 78N-10 | Deletion of Statement on Nurses' Shortage from Policy Manual | Lawrence L. Hirsch, M.D. for the Board of Trustees |
| 78N-11 | Deletion of Statement on Fee Schedules from Policy Manual | Lawrence L. Hirsch, M.D. for the Board of Trustees |
| 78N-12 | Deletion of Ethics Statement from Policy Manual | Lawrence L. Hirsch, M.D. for the Board of Trustees |
| 78N-13 | Revision of Policy Statement on Comprehensive Health Planning | Lawrence L. Hirsch, M.D. for the Board of Trustees |
| 78N-14 | Deletion of Community Health Week Statement from Policy Manual | Lawrence L. Hirsch, M.D. for the Board of Trustees |
| 78N-15 | Amendment to Chapter IX, Section 2, of the Bylaws Revising Areas of Concern of Council on Economics and Peer Review | James Laidlaw, M.D. for the Board of Trustees |
| 78N-16 | Amendment to Chapter IX of the Bylaws Describing the Committee on Third Party Payment Processes | James Laidlaw, M.D. for the Board of Trustees |

| *Number* | *Subject* | *Introduced By:* |
|---|---|---|
| 78N-17 | Amendment to Chapter IX of the Bylaws to Describe the Areas of Concern of the Council on Medical Service | James Laidlaw, M.D. for the Board of Trustees |
| 78N-18 | Amendment to Chapter IX of the Bylaws Expanding the Charge to the Council on Affiliate Societies | James Laidlaw, M.D. for the Board of Trustees |
| 78N-19 | Streamlining Operation of the Interim Session of the House of Delegates | P. John Seward, M.D. for the Board of Trustees |
| 78N-20 | Lowering Malpractice Insurance Rates as Cost Containment Measure | Samuel J. Schimel, M.D. |
| 78N-21 | IMJ Publication of Clinical Materials from ISMS-Sponsored Meetings | Robert R. Hartman, M.D. for the Board of Trustees |
| 78N-22 | How Then Shall We Define Life? | H. Frank Holman, M.D. |
| 78N-23 | Resident Delegate from Illinois to AMA House of Delegates | James DeBord, M.D. for the Resident Physician Section |

*For further information about the 1978 Interim Meeting, please contact the ISMS offices.*

# Doctor's News

**SPECIAL PROGRAM ON ALCOHOLISM**—The ISMS Student Business Session plans to hold a special educational program in alcoholism treatment during the AMA Interim Meeting. The program, sponsored by a grant from the Illinois Department of Mental Health and Developmental Disabilities, Division of Alcoholism, is scheduled for Friday afternoon, December 1, 1978, at the Palmer House, Chicago.

Members of the ISMS Scientific Speakers Bureau Alcoholism Roster will discuss several medical aspects of alcoholism. Topics will include acute care for crisis intervention and withdrawal, fetal alcoholism syndrome, and the increasing problem of teen drinking.

All interested parties are invited to the program, which will carry three hours of Category 2 CME credit for physicians. There is no admission fee. For further information, contact the ISMS offices.

**ARTHRITIS AND RHEUMATOLOGY** have been added to the list of available topics in the Southern Medical Association Dial Access System. The Dial Access, is a system of taped messages giving diagnostic and therapeutic information, which are available to physicians through a toll-free telephone number. A program on infectious diseases is planned in coming months.

If you are interested in obtaining a copy of the catalog listing of diagnostic messages from Dial Access, please write the SMA offices at 2601 Highland Avenue, Birmingham, Alabama 35205.

**EPIDEMIOLOGY FELLOWSHIPS AVAILABLE**—The University of Illinois School of Public Health has announced that both pre- and post-doctoral fellowships are available for study of the epidemiology of cancer and other environmental health problems. The fellowships, supported by the American Cancer Society and the National Institute of Environmental Health Sciences, include tuition and fees, stipends, and some research expenses.

For further information, contact Dr. H. M. Gelfand, Director, Epidemiology Program, School of Public Health, University of Illinois, P.O. Box 6998, Chicago 60680.

**NEWS FROM TEXAS**—Two studies from the University of Texas M.D. Anderson Hospital and Tumor Institute have brought evidence that protected environments reduce the risk of infection for cancer patients, particularly those with acute leukemia and malignant lymphoma. (Infection has been found to be the cause of death in 75% of the former and 50% of the latter group). Protected environments, the study found, greatly reduced the infection risk and permitted more intensive treatment, thus increasing the chances for a complete remission. Gerald P. Bodey, M.D., medical director of the Clinical Research Center that includes the special protected unit, was quoted reporting a 90% complete remission rate for first remission and the lowest incidence of infection ever recorded at that hospital. (The treatment includes antibiotics within the protected environments during chemotherapy).

**PHYSICIANS IN THE NEWS**—**Robert S. Blacklow, M.D.,** former associate dean at Harvard, has been named vice president for medical affairs and dean of Rush Medical College. . . . **Robert K. Anzinger, M.D.,** Chicago, has been elected to the American College of Emergency Physicians' Board of Directors. . . . **Leo M. Henikoff, M.D.,** was recently elected vice president for Inter-Institutional Affairs at Rush-Presbyterian-St. Luke's Medical Center in Chicago. Dr. Henikoff will be responsible for liaison within the medical center, seven affiliated hospitals and three associated institutions, as well as an academic network including 14 colleges and universities in six states.

**DOCTORS INVOLVED IN POLITICAL PROCESS**—*IMJ* recently received notice of the candidacy of Edmund R. Donoghue, M.D., for trustee of the University of Illinois. Doctor Donoghue, vice chairman of the department of surgery at St. Joseph Hospital in Chicago and former chairman of that department as well as a former president of the medical staff, is optimistic about his candidacy. A teacher and lecturer who has been affiliated with the Northwestern, Loyola and Chicago Medical schools, Doctor Donoghue has emphasized the need for a physician on the UI Board of Trustees. Of the total UI budget, he has said, 30% is allocated to the medical school and allied health sciences. But no current UI Trustee has attended medical school.

Although no physicians are currently listed on the roster of Illinois legislators, physician's spouses are included. Michael A. Abramson, (R)-Chicago, and Mary Lou Sumner, (R)-Dunlap, are among those who meet these qualifications. In addition, Edward E. Bluthardt, (R)-Schiller Park, is a physician's son, as is Illinois Governor James R. Thompson.

**ATTENTION, GENEALOGY BUFFS**—A special lecture is scheduled for Saturday, October 28, at the Prospect High School Auditorium, 801 Kensington Road, Mount Prospect, IL., at 1:30 p.m. James Hansen, reference librarian for the Wisconsin State Historical Society Library will discuss the genealogical holdings and activities of that group. Tickets are $5.00. For further information, telephone 312-253-1700, or write to: Continuing Education Office, 799 W. Kensington Road, Mount Prospect, IL 60056. (Please make checks payable to "Township High School District 214).

**GERIATRIC PSYCHIATRY GAINS EMPHASIS**—The National Institutes of Health have extended a three-year training grant in geriatric psychiatry to Jack Weinberg, M.D., a professor of psychiatry at Rush-Pres.-St. Luke's Medical Center and Lawrence Lazarus, M.D., an assistant professor at Rush and psychiatric consultant to the Johnston R. Bowman Health Center for the elderly.

**NEW CME PUBLICATIONS**—The Illinois Council on Continuing Medical Education has announced that two new free publications are available. "Setting Directions in CME, Purpose, Goals & Objectives," and "CME Planning Checklists," are the two new, helpful "how to do it" publications. A charge of $4 per copy for the first and $3 per copy for the second booklet will be assessed for interested parties who are neither ISMS members nor CME Sponsors. Further information may be obtained by writing the Illinois Council on Continuing Medical Education, 55 E. Monroe St., Chicago 60603.

## *President's Page*



# Interim Session To Focus On Key Issues

Next month's interim session of the ISMS House of Delegates will focus on key issues confronting the profession, and also on the Society's method of dealing with them.

Among the subjects of debate will be our stance concerning introduction by AMA of another NHI bill; recommendations of the National Commission on the Cost of Medical Care; and the Voluntary Effort to control health costs. Another key issue will be the structure of the interim session itself.

When the number and magnitude of volatile issues began increasing, the interim session was created as a logical method of allowing timely action by the policy-making House of Delegates. These shorter meetings were designed to focus on one or two issues. However, with each successive session, the scope and volume began to resemble that of the annual meeting—defeating to some degree the original purpose.

The interim session is an important part of the ISMS policy-making process. It ensures that the Society's leadership has the benefit of membership input while an issue is still considered "hot." The volume and diversity of resolutions now are threatening the ability of the House to deal with each subject during the abbreviated interim meeting. In an effort to preserve the two-day format, the Board of Trustees will submit a recommendation to streamline the meeting. The Board's suggestions will be presented in a resolution which, if adopted, will limit the scope of deliberation.

Under the proposed revamping, only matters deemed urgent by the Board of Trustees, AMA delegation or the Committee on Rules and Order of Business would be accepted for consideration, although any proposal would be considered after approval by a two-thirds majority of the House. Resolutions postponed as less than urgent automatically would be placed on the agenda for the House's annual meeting.

To ensure that your views are adequately represented on all issues, urge your delegates to attend the November meeting. Only through widespread participation can ISMS remain an effective voice for Illinois physicians. ◄

David S. Fox, M.D., President

# Physician Recruitment Program

*In an effort to reduce the number of towns in Illinois needing physicians, the Physician Recruitment Program and the Doctor's Job Fair, are publishing synopses in the Journal.*

*Physicians who are seeking a place to practice or who know of any out-of-state physicians seeking an Illinois residence are asked to notify the Program.*

*Any areas wishing to be listed should contact: Mrs. E. Duffy, Physician Recruitment Program, ISMS, 55 E. Monroe, Suite 3510, Chicago, 60603.*

*Announcing . . .*

## The 1978 DOCTOR'S JOB FAIR
## December 10, 1978
## Sheraton-OakBrook Hotel

*For further information contact:*

Physician Recruitment Program
Suite 3510 — 55 E. Monroe
Chicago, IL. 60603
312-782-1654

**ARCOLA**: Wanted-American trained F.P. to join established F.P. in active practice. Must do some O.B. Guaranteed salary and benefits. Eventual partnership. Robert N. Arrol, M.D., 126 S. Locust, Arcola, 61910. (217) 268-4444, or 268-4404. (12)

**ATKINSON**: Due to recent death of town's physician, a modern clinic with all facilities is available to a family physician who wants security and a wonderful place to practice. Hammond Henry Hospital only 8 miles away. Excellent grade and high schools and near Black Hawk Junior College. 30 miles to Quad City area, 140 miles to Chicago and 60 miles from Peoria. All recreational facilities nearby. CONTACT: John W. Ellis, Mayor, Atkinson 61235. (309) 936-7566. (12)

**AURORA**: Opening in General Internal Medicine with 40 man group. Complete office facilities. Good starting salary. Contact: L. E. Snyder, M.D., 1870 W. Galena Blvd., Aurora 60506. (312-859-6700) (1)

**CHICAGO**: Opportunities Available for Family Practitioners in a single specialty clinic setting. Association as a satellite facility with a 265 bed community hospital. Opportunity to build own practice with financial assistance available. Contact: Teryl R. Filebark, 1044 N. Francisco Ave., Chicago 60622. (312) 278-8800. (9)

**CHICAGO**: Major Chicago based retailer seeking corporate physician. Up-to-date, modern facilities, regular hours and comprehensive employee benefits make this a very desirable position. Please send resume with salary requirements. Contact: Professional Employment Director, Sears, Roebuck & Co., D/707-2, Chicago 60684 (1)

**ELGIN**: Psychiatrist, ¾ time position with CMHC. Provide leadership and direction of medical and psychiatric aspects of clinical program, consult with staff, provide direct service to a wide variety of patients. Experience: past residency, preferably Board certified. Resume and salary requirements would be helpful to: Jack Crook, Director of Programs, Fox Valley Mental Health Center, 384 Division, Elgin, 60120, (312) 695-1115. (10)

**FAIRBURY**: Population 3,500. Rural area serving a population of more than 16,000. Excellent practice opportunity for family practitioner or internist interested in family practice. Enjoy life and your practice in an area which offers excellent facilities and a personal, friendly atmosphere; join the staff of 112-bed JCAH accredited community hospital. Write: Frank Brady, Administrator, Fairbury Hospital, Fairbury, 61739, or call collect (815) 692-2346. (10)

**HARVARD**: An internist, OB-GYN for Northern Illinois commuter suburb. New hospital, good schools, guaranteed salary and benefits based on qualifications. Close to resort areas. A solid community economically. Contact: Dr. John P. Hill, 502 N. Hart, Harvard 60033. (815-943-5151) (1)

**LA GRANGE:** Western suburb of Chicago, medium sized hospital. Opening for Director of medical affairs, new position, full time. Work with medical staff on CME, medical staff affairs, Family Practice Residency Program and University affiliation. Contact, Administrator, 312-352-1200. (2)

**LISLE:** Physician needed to assist me in handling my very extensive private family practice. Salary open, good opportunity for this relationship to merge into a partnership association. CONTACT: M. Sinkovits, 4513 Lincoln Ave., Lisle 60532. (312) 968-2735. (12)

**MACOMB:** GP-FP 12 month contract practice—University Health Service. Outpatient clinic—no OB, Surgery. Fringes include hospitalization, paid vacation, retirement, etc. Approximately 13,000 students, city 23,000. Competitive negotiable income. Equal opportunity affirmative action employer. Contact: C. E. Hughes, M.D., Director BEU Health Center, WIU, Macomb 61455. (1)

**MINIER:** General or family practitioner for rich agricultural area near Bloomington. Large practice waiting due to death of doctor. Office with X-ray and other equipment, very reasonable. Unusual opportunity. Contact: Harvey Graff, Minier 61759. (309) 392-2345 or 392-2120. (10)

**OSWEGO:** Family physician or internist to join group of four in a small town primary care clinic. Two full-service hospitals nearby. One hour west of Chicago. Dr. A. Haan, Oswego, 60543. (312) 554-8431. (11)

**OTTAWA:** Opening in fields of Internal Medicine and Family Practice with multi-specialty group of nine physicians. Community, 20,000 plus. 154 bed hospital under five years old. Latest equipment. One and one-half hours from Chicago and Peoria. Near State Parks. Excellent school system. Close to Jr. College and State Universities. Salary negotiable. CONTACT: Mrs. Van Buren, Ottawa Medical Center, 313 W. Madison, Ottawa 61350. (815) 433-1010. (10)

**PAXTON:** Paxton Community Hospital is enlarging its medical staff due to expansion of the facility and has openings for Family Practitioners to locate in the community. A 30 bed, general short term acute hospital offers full services to the community except for OB. The hospital, in East Central Illinois, is approximately two hours from Chicago, St. Louis, and Indianapolis, and 30 minutes from University of Illinois. The hospital is fully accredited by the JCAH. Contact Mr. David Polge, Administrator, Paxton Community Hospital, 651 East Pells, Paxton 60957. Phone 217-379-2387.

**PEORIA:** Economical sound central Illinois community of 250,000 situated in picturesque river valley has need for family physicians and general internists to practice in a 300 bed community hospital affiliated with the University of Illinois, College of Medicine. Office space and financial assistance available. "A GOOD PLACE TO PRACTICE GOOD MEDICINE." Contact: John A. Smith, Administrator, Proctor Community Hospital, 5409 N. Knoxville, Peoria 61614. (309-691-4702) (3)

**WEST FRANKFORT:** Population 10,000, county 42,000. Coal mining growth area (1,200 new jobs). Offices available near hospital. On I57/24 in Southern Illinois. Major university near. Good highways, and recreation. Need OB-GYN, IM-CV, IM-GP and FP. Financial assistance. Contact: Wm. D. Palmer, Administrator, UMWA Union Hospital, 507 W. St. Louis St., West Frankfort 62896. (618-932-2155) (1)




# An open letter to Physicians

Many physicians are seeking relief from the ever increasing pressures of private practice. If you are a physician, and less than 56 years of age, the United States Air Force Medical Service offers you an alternative and a unique challenge.

The Air Force physician participates in a group practice environment with the entire spectrum of medical specialties available. Air Force Hospitals are accredited and are fully equipped. Health care is provided to every patient without regard for his ability to pay.

Benefits provide a secure and satisfying lifestyle, including 30 days of annual paid vacation, professional pay and recreational opportunities.

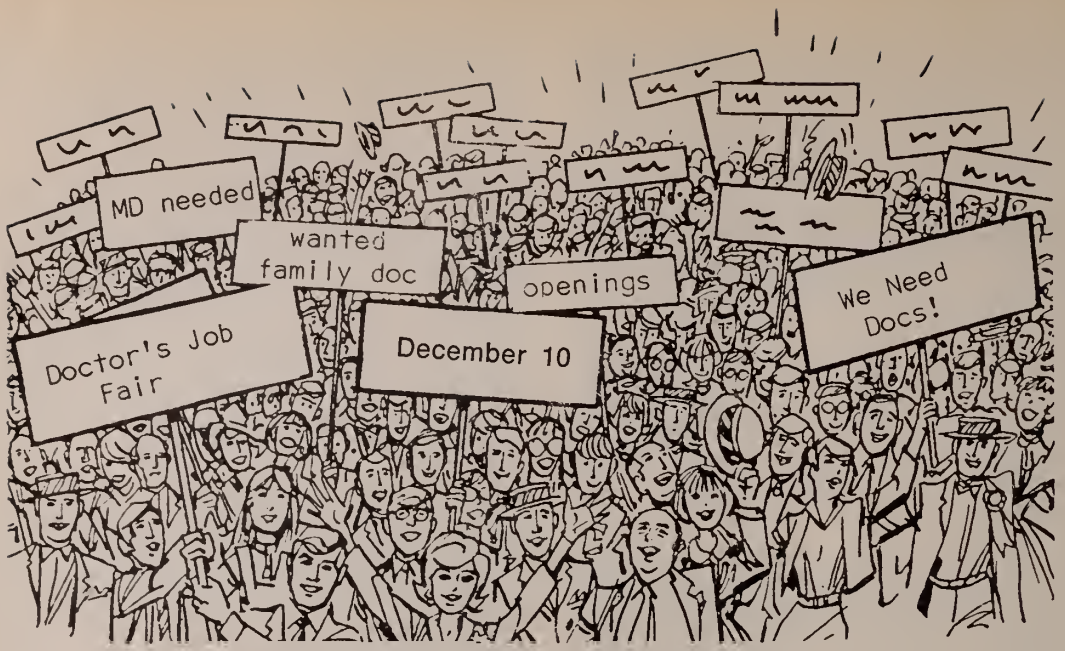
Consider the Air Force as an alternative to your present practice. Positions are available in primary health care delivery, and a few major medical specialties.

Starting salaries and rank are commensurate with education and experience. Assignment to a specific Air Force Hospital within the United States or overseas may be arranged.

Consider Air Force Medicine. Excellent pay and benefits, professional challenge and educational opportunities make the Air Force Medical Service a viable alternative to private practice.

**1st Lt. Donald T. Davies**
**111 N. Wabash Ave., Suite 1805**
**Chicago, Ill. 60602**
**312-263-1207**

# Air Force. A great way of life.




# ILLINOIS WANTS YOU!!

THE DOCTOR'S JOB FAIR
10:00 a.m.-4:00 p.m.
December 10, 1978
Sheraton-Oakbrook
1401 W. 22nd St.
Oak Brook, Illinois

Meet with the representatives from Illinois Communities . . . and YOU WILL BE SURPRISED at what they have to offer! Over the past year, 20 of your colleagues have found the community of their choice through the DOCTOR'S JOB FAIR.

For more information, please complete and return the attached form.

---

7th ANNUAL DOCTOR'S JOB FAIR

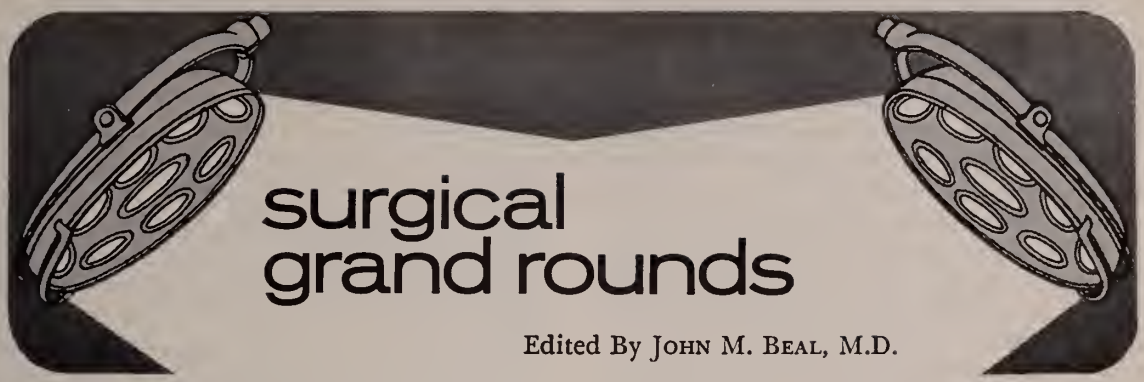
**PHYSICIAN RECRUITMENT PROGRAM**
Illinois State Medical Society
55 East Monroe — #3510
Chicago, Illinois 60603

Include Hotel Reservation Card _____

NAME _____

ADDRESS _____

CITY, STATE, ZIP CODE _____




Edited By JOHN M. BEAL, M.D.

*Surgical Grand Rounds are held weekly on Tuesday at 5:00 p.m. in the Offield Auditorium of the Passavant Pavilion of Northwestern Memorial Hospital. Patient presentations from Northwestern Memorial Hospital and the Veterans Administration Lakeside Hospital form the basis of the discussions. This case report was part of the Surgical Grand Rounds of November 22, 1977.*

## *Case Report*

# Torsion of the Testis

**Dr. John Sommer:** A 25-year-old man was admitted to the Northwestern Memorial Hospital with five hours of right lower quadrant pain, which subsequently localized to the right testicle. The pain was later described as radiating from the testicle into the right lower quadrant. He had experienced some nausea but no vomiting. He had neither urinary complaints nor prior testicular pain.

He was afebrile at the same of physical examination. His abdomen was soft with some mild tenderness in the right inguinal region. The penis was normal and the right testicle was elevated in the scrotum. Skin overlying the testicle was somewhat edematous and slightly warm. The position of the epididymis on this side was normal and the testicle was swollen and tender. Rectal examination and examination of his prostate was also normal. His urinalysis was unremarkable and he had a white blood cell count elevation of 12,200. The impression was a torsion of the right testicle. He was taken to the operating room where a right transverse scrotal incision was made under general anesthesia.

A moderate amount of hydrocele fluid was removed. A 360° counter-clockwise rotation of the testicle, intravaginally, was found. The testicle itself was swollen and cyanotic. It was derotated and fixed to the dartos. After this, the left testicle was attached to the dartos in a similar manner through a separate left scrotal incision.

This patient is a little older than the typical patient with torsion of the testicle. This problem usually is seen around the age of puberty. It is not really a torsion of the testicle, but should be properly termed torsion of the spermatic cord. The torsion of the cord causes loss of the vascular supply to the testis.

There are two forms of torsion of the testicle. The most common is the intravaginal form, as in this case. In this form, the testicle twists within the tunica vaginalis because of anomalous suspension. A less common type is extravaginal torsion. This is primarily a problem in newborns. The newborn testicle is very mobile and the tunica have not become attached to the scrotal wall. In the extravaginal torsion, newborns present with a painless mass in the scrotum and discoloration of the scrotal wall. Exploration should be performed promptly so that the torsion can be corrected with attachment of the testicle to the scrotal wall.

The more common form, intravaginal torsion, is secondary to anomalous testicular descent. Normally, the anterior half of the testis is covered by tunica vaginalis, leaving the posterior

surface bare to form loose attachments to the wall of the scrotum. All the anomalies in the intravaginal torsion occur because of this anomalous suspension of testicle. As more than half of the testicle is usually covered by the tunical vaginalis, the testicle can thwart within the tunica vaginalis as a bell clapper. Anomalies of the epididymis, such as a partial attachment to the epididymis or a complete separation of the epididymis from the testicle can also be contributory, so the torsion can occur between the epididymis and the testicle. This may occur at any age, most commonly at puberty. The current high occurrence at puberty is attributed to differential size and growth of the testicles.

Symptoms can be a sudden onset of pain or an insidious gradual onset, which often occurs during sleep. It is estimated that there is an absence of previous testicular pain in 50% of reported cases. Pain usually progresses to become moderately severe and can radiate into the groin, lower abdomen and also into the lumbar area. There can be nausea and vomiting. Fever is not usually a symptom. Urinary symptoms are varied and frequent. On physical examination, the testicle is usually drawn up high in the scrotum on the affected side. The position of the epididymis is not always abnormal. If the testicle, as in this case, is rotated 360°, the position is normal. In epididymitis, elevation of the testicle should reduce the pain, but in torsion of the testicle, elevation should increase the pain.

**Differential Diagnosis**

The real problem is differentiation from acute epididymitis, incarcerated hernias, acute hydroceles and mumps. The recent history of parotiditis or of mumps in the family or mumps in the peers should be present. In epididymitis, pyuric should be present. Another distinguishing feature of torsion is that the testicle is raised in the scrotum. In torsion, the edematous mass of the spermatic cord is softer than the mass of acute epididymis. Abnormal suspension of the opposite testicle may be present, which will also indicate a similar abnormality of this affected side. Usually, it is an abnormality of one side or the other. There is a 50-80% chance of an abnormality of the opposite testicle.

In the emergency room, it is reported that people have been able to detort testicles. In theory, this sounds good; in practice, it is probably difficult because the testicle can rotate in either direction and rotate several times.

The standard operation is detorsion, fixation to the dartos, and exploration of the other side. I would like to mention the torsion of the appendices of the testicle. There are essentially four different testicular appendices, and again these most commonly occur around puberty. The appendix testis is the most common and normally occurs in 90% of normal individuals. The second is the appendix epididymis, which occurs in 30% of individuals. Thirdly, the paradidymus is an accessory appendix of the vas deferens, and fourthly, the vas aberrans of Haller attached to the epididymus.

Symptoms of torsed appendicies include acute onset of pain. The pain may be markedly debilitating. If seen early, this pain may be sharply localized to the torsed appendix. There is a physical sign, called the "blue dot sign" in which a blue dot of the infarcted appendage may be seen through the scrotal skin. If seen early, the torsed appendage may be palpated as a swollen tender mass. Later torsion of the appendage often has a red rash edema and later an inflammatory hydrocele. It is hard to differentiate from torsion of the testicle. Some people who have been sure of the diagnosis of torsion of an appendix have treated these patients conservatively. This is not recommended because pain from this is severe and debilitating for long periods of time; usually at least a week. The patient can be explored through a small scrotal incision and have the torted appendix ligated.

**New Diagnostic Tools**

I should mention two newer things in diagnosis of torsion of the testis. One is a scanning. This is done with Technetium-99 and having a scan taken about 10 minutes after the isotope is injected. The torsed testicle should appear as an oval area of decreased uptake. The main disadvantage is that scans are not available on a 24-hour basis and are difficult to schedule as an emergency. The survival of the testicle is considerably greater if surgery is initiated within the first seven hours. Probably these scans will increase the delay in therapy. The second thing is the use of the Doppler ultrasonic stethoscope. The Doppler examination is interesting in that you have the opposite testicle as a control. This is done by placing the Doppler on the anterior surface of the testicle. Normally, pulsations are heard over the testicle and will cease when the blood supply in the spermatic cord is compressed. In torsion of the testicle, pulsations will be absent. You can check this by compressing the blood supply of the opposite testicle to see if

pulsations will cease. There are two problems with the Doppler. (1) In the early torsion, only the venous return is compromised and (2) in more chronic forms, there are false readings because of the increase of blood to the area from inflammation.

**Dr. Earl Wendel:** In acute scrotal pain and swelling, it is basically better to explore the scrotum if there is a question of diagnosis. None of the newer diagnostic modalities are really that accurate. The average age in the group that present with torsion is about 14 to 18 years. Interestingly the changes are about 1 in 160 that a young male will reach the age of 25 having a torsion; it is fairly common entity. There are a number of things that predispose to it, among which are abnormal genital attachments. Terms that are sometimes used in reference to testicular abnormalities are the horizontal or transverse lie and the bell clapper deformity. These are basically anatomic abnormalities that predispose to a testicle undergoing torsion which relate to abnormal attachments in the scrotum.

The testicle, as most of you know, hangs in a fairly perpendicular position in the scrotum. If you are looking at a person from the side, the epididymis is more posterior than lateral. There really is something to the gubernaculum. There are attachments inferiorly and if you look at the scrotum straight on with the two scrotal compartments, the epididymus is more lateral. There is some posterior and medial attachment where the tunica vaginalis doesn't completely encompass this area. However, the tunica vaginalis can attach way high on the spermatic cord, so that the testicle really swings free. That is called the "bell clapper" deformity because it hangs free inside the tunica vaginalis.

Another common anomaly is called the transverse or horizontal lie, where there is such poor attachment to the testicle that it is mobile in the scrotum and you can actually spin these around if you choose, while you are examining them. Because the testicle is not attached at all, the testicles frequently assume a lie that is more or less transverse; instead of being perpendicular, it ends up going actually horizontally. Those frequently undergo recurrent twisting. Forty or 50% of the men with acute torsion will give a history of genital pain episodes, possibly due to a torsion that reduces spontaneously. They do reduce spontaneously and it has been said that the majority of them undergo detorsion or untwisting spontaneously at the time of induction of anesthesia. Certainly, 60 or 70% will untwist when you put the patient to sleep. There is a lot of crevasteric spasm that keeps this thing twisted rather than allowing it to relax.

The hallmarks are basically young males that present with acute scrotal pain and then begin to have swelling. If they haven't swollen too significantly, you can usually find an abnormal position of the testicle. The testicle may be riding high in the scrotum or there may be thickening of the cord where the twist actually is. If there is evidence of genital infection, it is more likely that they have epididymitis. However, if there is any doubt whatsoever, they should be explored, because the risk of exploration is really minimal (excepting the anesthetic). The salvage of the testicles with torsion is still only about 40 to 50% and the other half are lost due to late exploration, or non exploration.

**Dr. John Beal:** This is an important subject because it is usually an acute emergency and anyone might encounter it in the emergency room. As Dr. Wendel has just said, if it is not treated promptly, it causes the loss of the testes.

**Dr. James Hines:** When you mechanically detorse one in the emergency room without operating or it detorses itself, I want it made clear, do you then go back and do a fixation?

**Dr. Earl Wendel:** On both sides. I think that is important to emphasize. ◄


**COOK COUNTY**

**Graduate School of Medicine**

CONTINUING EDUCATION COURSES
STARTING DATES—1978-1979

CLINICAL & LABORATORY DIAGNOSIS OF HEMORRHAGIC AND THROMBOTIC DISORDERS, 2 days, October 20
SPECIALTY REVIEW SURGERY, PART I, October 23
RECENT ADVANCES IN PSYCHIATRY, 5 days, October 23
RECERTIFICATION REVIEW IN OB-GYN, 5 days, October 30
ADVANCES IN MEDICINE, 5 days, November 13
RECENT ADVANCES IN NEUROLOGY, 5 days, November 13
SPECIALTY REVIEW SURGERY, PART II, November 27
ADVANCES IN OB-GYN, 3 days, November 30
MANAGEMENT OF ACUTE CARDIAC PATIENT, November 29
SPECIALTY REVIEW UROLOGIC PATH. & X-RAY, December 4
SPECIALTY REVIEW THORACIC SURGERY, January 29

*Information concerning numerous other continuation courses available upon request.*

**Address:**

**REGISTRAR, 707 South Wood Street,**

**Chicago, Ill. 60612**

## Rheumatology Rounds

L. F. Layfer, M.D., and J. V. Jones, M.D., Contributing Co-Editors

# Acute Unilateral Ankle Swelling With Fever

A 65-year-old retired housekeeper was seen for right ankle swelling. Two days earlier she had awakened with a dull ache in her ankle. Pain was constant and intensified with walking, which rapidly became impossible. Warm soaks were not helpful and aspirin gave only minimal relief.

There was no history of trauma. She had experienced similar ankle pain ten years earlier but this had been milder and had abated within two days without treatment. Except for occasional knee stiffness, she had no other joint complaints. Other past history and review of systems revealed mild hypertension currently treated with a thiazide diuretic.

On examination, oral temperature was 38°C and blood pressure was 130/80. The right ankle was warm, erythematous and tender to even mild palpation. Pain was increased by ankle motion. Swelling was noted anteriorly and about both malleoli. The heel, midfoot, and forefoot were normal. The knees revealed mild crepitation but were otherwise normal. Other joints and the rest of the physical exam were unremarkable.

### Laboratory

Hematocrit was 39%. White blood count was 8700 with 58% polymorphs. SMA 18, coagulation studies, EKG and urinalysis were normal. Repeat values for calcium, phosphorous and uric acid were consistently normal. Blood and urine cultures were sterile. Chest X-ray was normal. X-rays of the right ankle were unrevealing. Joint aspiration revealed grossly turbid synovial fluid appearing purulent; mucin clot and viscosity were fair; white cell count was 32,000 with 63% polymorphs; glucose was normal; gram stain revealed rhomboid shaped crystals in white cells but no bacteria. Under polarized light examination, positively birefringent rhomboid shaped crystals were identified. Synovial fluid cultures were sterile.

### Comment

Rheumatic syndromes associated with calcium pyrophosphate dihydrate (CPPD) crystal deposition in articular cartilage are combinations of three basic manifestations of such deposition.[1] When calcium crystal deposits become dense enough to be seen roentgenographically, the X-ray picture of chondrocalcinosis[2] is produced. Common sites for this are menisci and articular cartilage of the knee, triangular cartilage of the wrist, and the symphysis pubis. (Fig. 1 and 2) Other joints and even intervertebral discs are occasionally involved. When CPPD crystals are shed from cartilage into synovial fluid, an acute inflammatory response similar to that produced by urate crystals is manifested. Attacks most commonly take the form of an acute monoarticular arthritis of large joints resembling gouty attacks (hence the name "pseudogout"), but may also be polyarticular and subacuate, resembling other common inflammatory arthritis conditions.[3] Such attacks are not limited to joints which have chondrocalcinosis on X-ray. Also associated with CPPD deposition is the simultaneous degeneration of cartilage. This results in clinical and radiographic pictures similar to osteoarthritis of the involved joint. Occasionally the degeneration may be severe enough to resemble a charcot or neuropathic joint.

Diagnosis of CPPD deposition states is made by typical X-ray pattern of calcification in peripheral joints and by identification of positively birefringent rhomboid crystals in synovial fluid under polarized light.[4] Any ordinary microscope may be readily adapted for use as a polarizing instrument with little expense.[5] Crystals are visible by gram stain under oil emmersion, but identification of type of crystal (eg: urate or CPPD) is not possible by this method. Other causes of rheumatic disease must be ruled out.



**Figure 1**

**Chondrocalcinosis of the knee: typical calcification can be seen in the fibro- and hyaline cartilage (arrows).**



**Figure 2**

**A thin line of calcification can be seen in the symphysis pubis.**

Attacks of pseudogout may occasionally occur simultaneously with such diseases.

The cause of CPPD deposition is unknown. Several metabolic diseases have been associated with it (Table 1) but as yet no clear biochemical abnormality leading to such deposition has been described.

**Table 1**

**Diseases Associated with CPPD Deposition**

| | |
|---|---|
| **Idiopathic** | **Ochronosis** |
| **Familial** | **Gout** |
| **Hyperparathydroidism** | **Diabetes Mellitus** |
| **Hemochromatosis** | **Hypothyroidism** |
| **Wilson's Disease** | **Hypophosphatemia** |

Therapy is non-specific.[3] Acute attacks are treated in the same way as are acute attacks of gout. Short courses of indomethacin, phenylbutazone, or systemic or local corticosteroids are generally effective. Colchicine may occasionally give relief but is not uniformly effective. At present, there is no prophylaxis against recurrent acute attacks. Degenerative joints are treated with medical and surgical regimens similar to those used for osteoarthritis. Associated metabolic diseases should be sought and treated appropriately. It is not yet clear whether treating an underlying associated disease will influence the course of the CPPD-related articular disease.

## Conclusion

The finding of crystals in synovial fluid typical for CPPD suggested an acute pseudogout attack as the etiology of the ankle symptoms in the present case. Subsequent X-rays of knees, wrists, and pubis showed typical chondrocalcinosis consistent with such a diagnosis. An associated metabolic disease could not be found. The patient was treated with bed rest and high dose indomethacin. Marked reduction is swelling occurred within 48 hours and complete resolution within 96 hours. She was discharged on no medication, and on six month follow-up had no recurrent attacks. ◄

## References


1. McCarty, D. J.: "Calcium Pyrophosphate Dihydrate Crystal Deposition Disease: Nomenclature and Diagnostic Criteria," *Ann. Intern. Med.*, 87:240-242, 1977.
2. Resnick, D. Niwayama, G. Goergen, T. A., *et al.*: "Clinical, Radiographic, and Pathologic Abnormalities in Calcium Pyrophosphate Dihydrate Deposition Disease: Pseudogout," *Radiology*, 122:1-15, 1977.
3. McCarty, D. J.: "Clinical Aspects of CPPD Crystal Deposition Disease," *Clinics in Rheumatic Disease*, 3: 61-89, 1977.
4. Gatter, R. A.: "Use of the Compensated Polarizing Microscope," *Clinics in Rheumatic Disease*, 3:91-103, 1977.
5. Fagan, T. J. and Lidsky, M. D.: "Compensated Polarized Light Microscopy Using Cellophane Adhesive Tape," *Arth. and Rheum.*, 17:256-262, 1974.




# Report on the 1978 AMA-RPS Annual Meeting

By Linda L. Hughey, M.D./Wilmette

*This is a monthly column which welcomes contributions, comments, and questions from interested readers. Address all correspondence to Dr. Linda Hughey, c/o the Illinois Medical Journal, 55 E. Monroe, Chicago, Ill. 60603.*

## Chairman's Report

As chairman of the Illinois Resident Physician Section, requests for resident participation in various national committees frequently come to my attention.

I would like to pass some of these opportunities on to the resident membership at large in hope that Illinois could contribute resident input to various policy-making organizations.

For example, there will soon be an opening for a resident on the Commission on Emergency Medicine. The following AMA councils seek residents for openings that will occur in June, 1979.

Council on Constitution & Bylaws
Council on Medical Services
Council on Scientific Affairs
Council on Legislation

The commission is seeking a "non" emergency medicine resident. Members of the AMA councils will be elected in June, 1979, except for the resident member of the Council on Legislation, who is appointed by the AMA Board of Trustees.

For further information, call C. Jay Brown at AMA in Chicago 312-751-6786.

These AMA councils make policy for the 70,000 interns and residents throughout the country and, therefore, resident input is critical.

Ira Isaacson, M.D.
Chairman, ISMS/RPS

### Dates to Watch

Nov. 4-5 (Sat.-Sun.) ISMS Interim Meeting at the Wagon Wheel Lodge, Rockton, Ill. Opening session starts at noon on Nov. 4. If you are interested in attending and/or car pooling to meeting, please contact Perry Smithers at the Illinois State Medical Society office and one of the ISMS RPS officers will contact you. Some RPS funds may be made available to cover expenses of residents wishing to attend.

Dec. 10: "Doctor's Job Fair" co-sponsored by the ISMS. Watch future columns for details.

Dec. 1-2: American Medical Association Resident Physician Section (AMA-RPS) annual meeting in Chicago. Delegate positions are available; please contact Dr. Ira Isaacson through the ISMS if you would be interested in attending.

### Cost Containment Commentary

Omnimedical Services, Inc. introduced a brain scan machine last November which cost $120,000 as opposed to the usual going rate of $350,000. This CAT scanner was called the "Omni 4001," in a not-so-subtle reference to a California Assembly Bill 4001 which required hospital certification for any purchases above $150,000. The new scanner brings up several cost containment issues:

1) Does decreasing the initial cost of a technical device make total costs increase by causing utilization to increase?
2) Are hospitals installing these expensive and sophisticated machines because of a real need for them or because they represent a high-income test?
3) Are residents and young physicians in any way contributing to the trend toward "a CAT-scanner in every hospital" by *expecting* advanced technology as a prerequisite to setting up practice in a given area?

Almost all residents are trained in fairly large, advanced medical centers. Having trained at an institution where obtaining an EMI scan is often easier than doing a spinal tap, it is small wonder that residents going in to practice tend to gravitate towards centers which offer more sophisticated support services. Should we or can we do anything about the trend?

# *Viewbox*

*(Continued from page 185)*

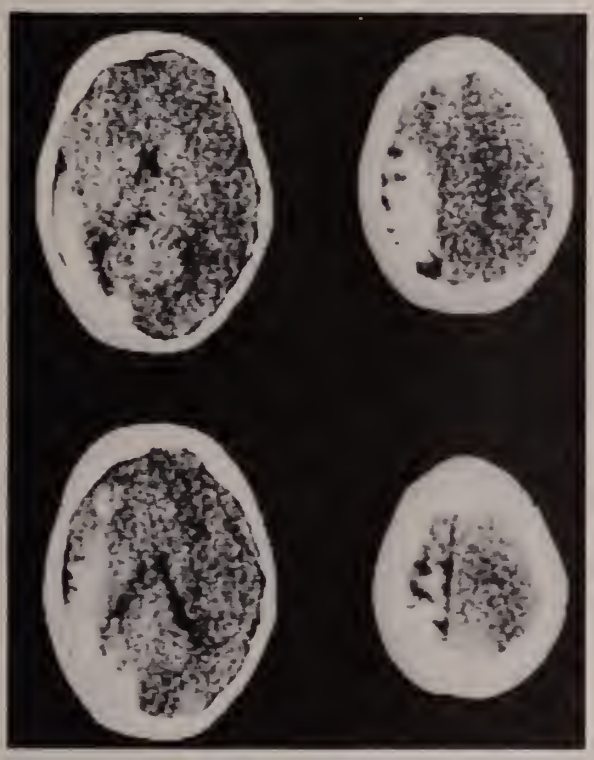


**Figure 2**

**DIAGNOSIS: Sturge-Weber Syndrome**

The skull films show superficial "tram track" calcifications in the parieto-occipital area. These are clearly intracranial and could not be caused by material in the hair.

Intracranial tumors (meningiomas, astrocytomas, oligodendrogliomas) usually exhibit rather coarse and poorly defined calcification; meningeal calicfications of inflammatory origin are usually basal in location and when situated over the convexity are diffuse and poorly defined.

The Sturge-Weber Syndrome is congenital and characterized clinically by unilateral angiomatous lesions of the face, hemiparesis of the opposite side, mental retardation, and seizures.

The gyriform calcifications seen on the skull X-rays are subcortical and can be seen on the C.T. scan (Figure 2). They are associated with angiomas of the leptomeninges which are usually parieto-occipital in location.

This case is presented in order to remind the reader of the clinical and radiological manifestations of this rare entity and its rather pathognomonic features.

**References**


1. Alexander, G. L., Norman, R. M.: "The Sturge-Weber Syndrome," Bristol, John Wright & Sons, Ltd., 1960.
2. Peterman, A. F., Hayles, A. B., Dockerty, M. D., Love, J. G.: "Encephalotrigeminal Angiomatosis (Sturge-Weber Disease): Clinical Study of Thirty-Five Cases," *JAMA,* 167:2169, 1948.
3. Weber, F. P.: "Right-sided hemi-hypertrophy resulting from right-sided congenital spastic hemiplegia with a morbid condition of the left side of the brain revealed by radiograms," *J. Neurol. Psycopath.,* 3:134-139, 1960.



*Like a trip to New England*

**FAMOUS CRUTCHER INDIANAPOLIS ANTIQUE SHOW**

**Oct. 27-30, 1978**

**State Fairgrounds**
**1500 E. 38th (U.S. 36)**

INVESTMENT QUALITY
144 dealers—many from east
Free parking ADM. $2-4 days
11 A.M.-10:00 P.M.
Sunday 12 to 5 P.M.

**QUALITY CONTROLLED**
**EVERYTHING GUARANTEED**

Many national dealers
No other Indiana show compares in any way!

Jean Crutcher, Mgr.
7370 Old National Trail, E.
New Carlisle, Ohio 45344

*Case Report*

# Phencyclidine Psychosis

By Beverly J. Fauman, M.D. and Michael A. Fauman, M.D., Ph.D./Chicago

*Phencyclidine abuse has been increasing throughout the United States during the past ten years, predominantly among adolescents and young adults. A very small number of those who experiment with this drug develop a psychosis which characteristically persists for several weeks. In most of these patients, a history of poor premorbid function is found. A previously healthy 39-year-old man with no personal or family history of psychiatric disturbance developed a psychosis requiring several weeks' hospitalization after smoking a "reefer." The history and the hospital course suggest that this was most likely phencyclidine. The authors suggest that with the increasing use of phencyclidine, even psychologically healthy people who are not typical drug users may develop a phencyclidine-related psychosis.*

Phencyclidine, one of the most common illicit drugs in many cities[1-3] has been increasingly available as a drug of abuse since 1967.[4] Various reports have been published concerning its biochemistry, adverse effects, and acute and prolonged psychoses.[2,5-9] The typical user is a young person between 15 and 25 years of age, although adverse effects have been reported in patients ranging in age from 10 months to 33 years. The prolonged psychosis is an infrequent occurrance, generally affecting patients with a history of poor premorbid psychological adjustment. This report concerns a phencyclidine-induced psychosis in a previously healthy 39-year-old man.

The patient was a professional, married and the father of four. He was brought to the emergency department by his brother, who reported that there had been an abrupt change in the patient's behavior five days earlier, when he returned from a night out. He was thought to have smoked marijuana that night, although there was no history of excessive drug use. The abnormal behavior consisted of "moodiness," crying spells, sleeplessness, and apparent auditory hallucinations.

Several events were thought by the brother to be contributing to the patient's illness. He had been having an affair, which the wife had insisted he break off on the day of his behavior change; also his oldest son, who he had hoped would go to college, had instead left home two weeks earlier to join the service. There was some history of heavy drinking in the past, but none in recent months. There was no family or personal history of psychiatric illness. The patient had smoked marijuana on rare occasions with his sons.

The patient himself was unable to give any history on admission, although he had a perception that something was terribly wrong with his head. On physical examination he was an overweight, well-developed man appearing his stated age. Blood pressure was 172/120, pulse 96. He appeared anxious, was hyperalert and easily distractable. The remainder of the physical examination was within normal limits, except for an equivocal plantar response on the right.

Most strikingly, he appeared to understand questions and commands, but responded each time with a delay of 20 to 30 seconds. He was oriented to time, place and person, but had difficulty performing memory tests and had a very incomplete memory for the events of the previous five days. Calculations, judgements and abstract thinking could not be tested adequately because the patient grew increasingly agitated as his mental difficulties were demonstrated.

## Treatment

He was admitted to the inpatient psychiatric unit, where he improved gradually over the next three weeks. Initial improvement seemed directly related to placing him in isolation. All laboratory tests were normal, including liver function tests, computerized axial tomography of the brain, EEG, blood alcohol and carbon monoxide level. Blood and urine screen revealed no drugs. Lumbar puncture was attempted unsuccessfully on two occasions. Plantar reflex became normal on the second hospital day.

On the 12th hospital day, the patient described the precipitating event. He had been out with several friends when one of them passed around a "reefer." He realized that he was not "handling it well" and was upset by his inability to explain to his friends that he was having a bad experience. He began having accusatory auditory

BEVERLY J. FAUMAN, M.D., is an assistant professor in the department of psychiatry and division of emergency medicine at the University of Chicago Hospitals. She is the University of Chicago coordinator of continuing education at Riverside Hospital in Kankakee. Doctor Fauman is board certified by the American Board of Psychiatry and Neurology.

MICHAEL A. FAUMAN, M.D., Ph.D., is an assistant professar at psychiatry in the University of Chicaga department of psychiatry. Doctor Fauman is certified by the National Board of Medical Examiners.

hallucinations and became increasingly confused, a state which lead finally to his hospitalization.

### Summary

The phencyclidine psychosis is an extremely uncommon phenomenon. Susceptibility to a prolonged psychosis is generally related to a poor premorbid history, as is true of the psychosis induced by other illicit drugs. It is unusual to find such a severe reaction in a middle-aged, previously healthy patient. However, there are several features that characterize the reaction as an organic brain disorder.[10] The sudden onset and relatively rapid recovery, with confusion and agitation as the major symptoms are prime criteria. The history of smoking "reefer," which commonly is mixed with or is phencyclidine, and the observation that isolation brought about improvement, strongly suggest phencyclidine.[11,12] The setting of marital troubles and the recent departure of the oldest child probably contributed to the patient's susceptibility to a psychotic reaction. It is important for physicians to be aware of this entity, and the possibility of its occurrance in a previously well middle-aged person who is not a typical drug user. The evidence suggests that we will continue to see phencyclidine abuse increase.

### References

1. Cheek, F., Newell, S., Jaffe, M.: "Deceptions in the Ilicit Market," *Science,* 167:1276, 1970.
2. Burns. R. S., Lerner, S. E., Corrado, R., *et al,*: "Phencyclidine—States Of Acute Intoxication and Fatalities," *West J. Med.,* 123: 345-350, 1975.
3. Rainey, J. M., Crowder, M. K.: "Prevalence of Phencyclidine in Street Drug Preparations," *New Eng. Jrn. Med.,* 290:466-467, 1974.
4. Reed, A., Kane, A.: "Phencyclidine (PCP): Another Illicit Psychedelic Drug," *Journ. Psychedelic Drugs,* 5:8-11, 1972.
5. Tong, T. G., Benowitz, N. L., Becker, C. E., *et al.*: "Phencyclidine Poisoning," *JAMA* 234: 512-513, 1975.
6. Liden, C. B., Lovejoy, F. H., Costello, C. E.: "Phencyclidine: Nine Cases of Poisoning," *JAMA,* 234:513-516, 1975.
7. Fauman, B. J., Baker, F., Coppleson, L. W., *et al.*: "Psychosis Induced by Phencyclidine," *JACEP,* 4:223-225, 1975.
8. Fauman, B. J., Aldinger, G., Fauman, M. A., *et al.*: "Psychiatric Sequellae of Phencyclidine Abuse," *Clin. Toxicity* 9:529-538, 1976.
9. Cohen, S.: "Angel Dust," *JAMA,* 238:515-516, 1977.
10. Fauman, M. A., Fauman, B. J.: "The Differential Diagnosis of Organic Based Psychiatric Disturbance in the Emergency Department," *JACEP,* 6:315-323, 1977.
11. Luby, E., Gottleib, J., Cohen, B., *et al.*: "Model Psychoses and Schizophrenia," *Am. J. Psychiatry,* 119:61-67, 1962.
12. Stein, J.: "Phencyclidine Induced Psychoses. The Need to Avoid Unnecessary Sensory Influx," *Milit. Med.,* 138:590-591, 1972.

LOW-COST GROUP INSURANCE ANOTHER ISMS MEMBERSHIP PRIVILEGE

**THE GROUP DISABILITY PLAN** ● Provides up to $1,732.00 monthly in the event of disability caused by Accident or Sickness. ● Special Guaranteed renewal feature. ● Protect your income and security.

**BUSINESS OVERHEAD EXPENSE PLAN** ● Pays your office overhead expense when disability strikes. ● Premiums are Tax Deductible. ● Pays in Addition to the Disability Plan Benefits.

**THE BASIC MAJOR MEDICAL EXPENSE PLAN** ● In or out of Hospital Benefits up to $25,000.00 per Disability. ● Up to $100.00 Daily Hospital Room and Board maximum. ● Subject to choice of deductible and 80% coinsurance.

**EXCESS MAJOR MEDICAL PLAN** ● Provides up to $500,000 for Medical Expenses. ● Supplements any Basic Major Medical Plan and is available with a $15,000, $20,000 and $25,000 deductible. Low group rates. ● Truly catastrophic coverage.

FOR INFORMATION, ASSISTANCE & DETAILS CONTACT:

Administrators:
PARKER, ALESHIRE & COMPANY
ESTABLISHED 1901
Insurance

9933 N. Lawler Avenue
Skokie, Illinois 60077
Phone: 312-679-1000

# CLASSIFIED ADVERTISING

## POSITIONS & PRACTICE OPPORTUNITIES

**FULL TIME PHYSICIAN** for Industrial Clinic in Skokie. Surgical experience needed. Salary negotiable. Must have Illinois license. Call (312) 674-4800, Mrs. McCubbin.

**OPPORTUNITIES FOR PHYSICIANS IN INDIANA**—There are several excellent openings among the Indiana State Hospitals at various locations throughout the state for psychiatrists and physicians of other specialties, at most experience levels. A newly-revised salary schedule offers a very competitive income plus a generous package of fringe benefits. An adjunct practice is possible beyond the regular working hours and on-call responsibilities. Please reply with a copy of the c.v. to: Farabee & Associates, Inc., P.O. 8ox 472, Murray, KY 42071 or call (collect) (502) 753-9772. Farabee is retained by the Indiana Department of Mental Health.

**EMERGENCY DEPARTMENT PHYSICIAN:** 8ecome part of an expanding, dynamic multispecialty clinic in midwest university community of 100,000. Excellent salary, benefits. Write or call Medical Director, Carle Clinic, Urbana, IL 61801, (217) 337-3239.

**FAMILY PRACTITIONER**—To associate with one senior general practitioner and one surgeon in rural southern Illinois. Excellent educational system and recreation. Financially sound community. One hour from St. Louis. JCAH 72-bed hospital in Nashville. Association available now. Contact: T. K. Janssen, Administrator, Washington County Hospital, Nashville, Illinois, (618) 327-8236.

**PRIMARY CARE PHYSICIAN:** We seek a primary care physician, specialist or generalist, for JCAH-accredited hospital in central Illinois. Population: 4,500—service area 19,000. Hospital affilated with a major medical center and teaching hospital which provides opportunities for continuing medical education and support activities, ensuring against professional isolation. Hospital will furnish office in building on grounds and guaranteed base salary, plus other amenities. For further information write: 8ox 931, c/o IMJ, 55 E. Monroe, Suite 3510, Chicago, III. 60603.

**FAMILY PRACTICE PHYSICIAN** who is interested in obstetrics wanted to do primary care. $42,000 plus fringes (IRS-approved profit sharing plan) to start. Contact H. Osmus, Administrator, Hedges Clinic S.C., 222 Colorado, Frankfort, IL 60423; or (815) 469-2123.

**ILLINOIS—PEORIA**—Interviewing career Emergency Physicians for full-time openings starting immediately and Jan. 1. Opportunity to join young ACEP oriented physicians' group in 550-bed Medical-Surgical Hospital affiliated with Peoria School of Medicine. Good specialty backup. Flexible scheduling. Superior compensation with liberal fringe benefits including malpractice. Contact H. T. Stratton, M.D.; Methodist Medical Center, 221 NE Monroe, Peoria, IL 61636; (309) 672-4974 or (309) 672-5501.

**CHILD PSYCHIATRIST**—Full or part time. Modern residential treatment center for children & adolescents. Write or call Jose R. Sanchez, M.D., Medical Director, Chicago-Read Mental Health Center, 4200 N. Oak Park Ave., Chicago, III. 60634. (312) 794-4000.

**PEDIATRICIAN**—Full or part time. Modern residential treatment center for children & adolescents. Write or call Jose R. Sanchez, M.D., Medical Director, Chicago-Read Mental Health Center, 4200 N. Oak Park Ave., Chicago, III. 60634. (312) 794-4000.

**PSYCHIATRIST**—Adult Inpatient Services. Full or part time, for modern residential facility: Write or call Jose R. Sanchez, M.D., Medical Director, Chicago-Read Mental Health Center, 4200 N. Oak Park Ave., Chicago, III. 60634. (312) 794-4000.

**GENERAL PRACTITIONER, FAMILY PRACTITIONER,** needed for rural Illinois town near metropolitan area. Private office, full equipment and established practice available for sale or lease. Write: James R. Hastings, Executor, 301 NW 2nd St., Aledo, Illinois 61231, or telephone (309) 582-5388.

**PHYSICIAN WANTED.** Full or part time for fully equipped medical center. Large welfare practice. 2823 N. Clybourn, Chicago, III. 60618. Telephone—(312) 929-6999 or 664-3157.

**OCCUPATIONAL MEDICINE**—National corporation needs associate medical director in Skokie, Illinois; occupational medical experience desirable. Corporation dedicated to comprehensive health program for all employees; modern well equipped facilities; liberal fringe benefits include life and health insurance, excellent savings plan, malpractice insurance coverage, liberal vacation, holiday and sick leave policies, etc.; salary commensurate with position responsibilities, experience and professional training. Send resume in confidence to 8ox 935, c/o Illinois Medical Journal. An Equal Opportunity Employer.

**PHYSICIAN WANTED:** General medical services to be provided to psychiatric patients. Full and part-time positions available. Generous fringe benefits. Salary negotiable. 50 minutes from downtown Chicago. Contact Claude Roush, Superintendent, Manteno Mental Health Center, Manteno, Illinois 60950. (815) 468-3451.

**FAMILY PRACTICE PHYSICIAN** needed immediately to cover practice of well-established physician during period of illness, in East Moline, Illinois. Coverage needed for approximately six months after which take over of practice might be possible. Or, establishment of own practice in facilities available adjacent to Illini Hospital. For further details including financial information contact Brian P. 8ollman, Assistant Administrator, Illini Hospital, Silvis, Illinois 61282. Area Code (309) 792-9363.

**GENERAL SURGEON:** The Department of Surgery, Peoria School of Medicine, University of Illinois College of Medicine is seeking a Clinical Instructor or Assistant Professor to participate in programs of health professions education. The appointment is for 25% time. Candidates must be qualified or eligible for examination by the A8S. The University of Illinois is an Affirmative Action-Equal Opportunity Employer and encourages applications from members of minority groups and women. Closing date for applicants is September 30, 1978. Send letter with curriculum vitae to: William H. Marshall, M.D., Acting Chairman, Department of Surgery, Peoria School of Medicine, 123 S.W. Glendale Avenue, Peoria, IL 61605.

**LOCUM TENENS—EMERGENCY MEDICINE**—available in our 100 hospitals; monthly scheduling is flexible and according to your preferences; malpractice is paid, excellent hourly income according to your flexibility and hours worked. Call toll free 1-800-325-3982, ext. 220 for details.

**OPPORTUNITY IN FAMILY PRACTICE**—Two 8oard Certified Family Physicians need third physician. New office connected to new hospital (250 beds) with all ancillary and specialized services available. Any interested physicians please snd curriculum vitae to Link, Chapman & Associates, Inc., 1515 West Truman Road, Independence, Missouri 64050, or call collect 816-836-8200; 9:00 a.m. to 4:30 p.m.

**IN PATIENT CLINIC PRACTICE** at Illinois Developmental Centers; various locations. Monday through Friday, days only, no night or weekend call. Guaranteed income of $40,000-$50,000. Send CV to T. P. Cooper, M.D., 970 Executive Parkway, St. Louis, MO 63141, or call toll free 1-800-325-3982.

**EXCELLENT OPPORTUNITY**—for a physician in Cedar Rapids, Iowa. Excellent medical facilities in city. Assume practice of deceased sole practitioner of internal medicine. Office leased; laboratory and X-ray facilities close at hand. Write Trust Dept., P.O. 8ox 1807, Cedar Rapids, Iowa 52406.

**ORTHOPEDIC SURGEON** who desires to locate in a rural area of southern Illinois needed to serve two community hospitals. One hour from St. Louis. Good educational system for children. Excellent recreation. Reply: T. K. Janssen, Administrator, Washington County Hospital, Nashville, Illinois 62263.

**A PROGRESSIVE RURAL COMMUNITY** in midwestern Indiana desires to secure two or more general practitioners. Interested parties would find new schools, a new nursing home, new banks, good hospitals nearby, etc. A medical center with purchase option will be built to accommodate these physicians. Contact J. D. Piech, 1600 E. Liberty, Covington, Indiana. (317) 793-4818.

## FOR SALE, LEASE OR RENT

**MEDICAL OFFICE SUITE FOR RENT,** Lincoln-8elmont 8ldg. 715-1200 square feet, available at once in full service, elevator, active professional building. Call Gary Solomon, (312) 334-5400.

**MEDICAL CENTER FOR RENT.** Complete and ready to open. 4300 sq. ft. at 2301 E. 95th Street, Chicago. Large waiting rm., 18 exam rms., x-ray rm., central a/c & heat. Call Gary Solomon, (312) 334-5400.

**SUITE TO LEASE** for Internist, Pediatrician, Psychologist, Psychiatrist or other medical practice. Suite is located in a high quality building with a growing medical community situated across from a major hospital. The complex already includes an outstanding lab, X-ray facility, pharmacy and 16 professionals. Arrangement provides flexibility for the new tenant to share a suite with an existing practice, to have office built in newly created bare space and to participate in the ownership and direction of the complex. STRONG Property Managers, Ltd. Agents, 201 W. Springfield, Champaign, IL 61820. (217) 356-2617.

**LISLE-MEDICAL SUITE** available in prestigious modern building located on Rt. 53 in Lisle. X-ray facilities on premises. Zone controlled heating and air conditioning. Ample parking. Call 969-2850.

**FOR SALE:** Solo or Group Practice/south western Chicago suburb. Comprehensive Medical Center: Internal Medicine, OB-GYN, Pediatrics, Optometry, Dental, X-ray Equipment, Medical Lab and Pharmacy. 7000 sq ft., 15 fully equipped examining rooms plus business offices. Private parking. Estimated Annual Gross Income: middle six figures. Negotiable financing. Outstanding opportunity with excellent potential. Please direct inquires to: Box #933, c/o **ILLINOIS MEDICAL JOURNAL**, 55 E. Monroe, Chicago, IL 60603.

**GENERAL PRACTICE FOR SALE:** Excellent quality practice including industrial medicine. Northwest Suburban location with community hospital. Sale due to illness — Seller will assist in transition with hospital privileges, employees, etc. Contact Mark Gorman at 3916-67th Street, Kenosha, Wisconsin 53142. 414-654-9166.

**RANCH-STYLE MODERN MEDICAL-DENTAL BUILDING FOR RENT OR SALE:** Customized facilities to meet every medical and dental need. Ideal for family physician or group practice. 1500 to 2500 sq. ft. available. Armitage and Damen area, Chicago. Near St. Mary of Nazarene Hospital. Excellent location for neighborhood practice. (312) 472-5126 or 338-9347.

**FOR SALE:** 100 Mili-amp X-ray machine complete with fluoroscopic screen and developing tanks. Contact Wilson L. DuComb, M.D., 560-8th Street, Carlyle, Illinois 62231. Phone (618) 594-3451.

**INVESTMENTS:** Some choice MINI-SHOPPING CENTERS in the southwestern Chicago suburbs have come on the market. They have AAA tenants. One has a very attractive mortgage. Please call or write; Harrald E. Hayford, 1121 W. Ogden Avenue, Naperville, IL. (312) 420-2777.

**MEDICAL SUITES AVAILABLE,** near north side of Chicago, Logan square area, (312) BE5-7000, Mr. Fein.

**INGALLS MEMORIAL HOSPITAL**—New professional building, Harvey, Ill. Suites to doctors specifications. Housekeeping, maintenance, utilities included. Ample patient parking. Enclosed walkway to hospital. McKey & Poague Agents. (312) 331-4226.

**OPPORTUNITIES FOR PHYSICIANS IN CHICAGO WESTERN SUBURB:** Unique new medical office condominiums under construction in Wheaton/Carol Stream. Anticipated occupancy February, 1979. Opportunity to lease, purchase or lease with an option to purchase. Situated adjacent to existing Professional Park housing 35 physicians. Call (312) 665-9777 for details or brochure.

**SPACIOUS NORTHSIDE LAKEVIEW AREA** medical office for rent. Newly remodeled. Five examining rooms, carpeted. Large furnished waiting room. Available now. Interested in Spanish speaking doctors only. Growing Spanish speaking area. Near Ashland-Lincoln and Belmont. Pharmacy space also available, if desired. Please contact: Dr. Pedro O. Cabrera (Dentist) at 1442 W. Belmont or call 528-0068.

**RESIDENCE/OFFICE:** Prestigious face brick, one story home. 3 bedrooms, 1½ baths, 2 fireplaces, attached 2 car garage, full basement. (1,750 square feet net at $20 = $35,000) LOCATION: Five/eights acre zoned commercial at a traffic light corner of two major arteries in the City of Naperville. (27,B10 square feet net at $5 = $140,000) Total price $175,000. Contact: Harrald E. Hayford, 1121 W. Ogden Avenue, Naperville, Illinois 60540 (312) 420-2777.

**SUB-LEASE** active general practice of 30 years in northwest suburb of Chicago. Five rooms fully equipped—excellent location in medical building with pharmacy—furniture, instruments, and records. Immediate possession. Call (312) 697-4372.

**FOR THE INDIVIDUAL OR GROUP** desiring the ultimate piece of residential property in the western suburban area. Eleven plus acre estate in Naperville with nine hundred plus foot frontage on the Du Page River. Estate landscaped and covered with hundreds of beautiful, mature oak and blue spruce trees. Price $680,000. Shown by appointment. 355-8998.

## SITUATIONS WANTED

**INTERNIST**—29, university trained seeks partnership or group practice opportunity in Chicago area. Available July 1979. Box 929 or phone (312) 280-1156 after 6 pm.

**CERTIFIED PHYSICIAN'S ASSISTANT** with excellent medical, research and administrative background and experience. Available for Chicago or suburbs. Reply Box 934, c/o Illinois Medical Journal, 55 E. Monroe, Chicago, IL 60603.

**31 YEAR OLD MALE** 2 years post graduate training. Four years of emergency practice. High volume and high trauma in the four years. BLS provider BLS instructor ACLS provider seeking fee for service with partnership. C.V. on request. Available now. P.O. Box 425, Western Springs, IL 60558.

**31 YEAR OLD MALE** 2 years post graduate training 4 years of emergency practice. BLS, ACLS provider. BLS instructor ER experience in high volume and high trauma in the four years. Member AMA, ACEP. Seeking ER directorship. CV on request. P.O. Box 425, Western Springs, IL 6055B.

## MISCELLANEOUS

**REAL ESTATE MANAGEMENT:** You are a professional but are you a professional landlord? We are Professional Landlords who can manage your property completely so that you can devote full time to your profession. If you own apartment complexes, office buildings or shopping centers, our management skills can reduce your expenses and maximize your cash flow. COMBINED CAPITAL ASSOC., Suite 2015 Tribune Tower, 435 No. Michigan Ave., Chicago, IL 60611. Tel. (312) 337-6655.

**PECAN HALVES—WALNUTS—SLICED ALMONDS!** Three-quart sampler, $9.95 postpaid; Canecreek Farm, Box 2727-MJ, Cookeville, TN 38501.

## GUARANTY FUND CERTIFICATE

**GUARANTY FUND CERTIFICATE:** Class 8 Inter-Insurance Exchange Certificate for sale (previously class 5). Call 266-1977, 9-5 P.M.

**GUARANTY FUND CERTIFICATE:** Wanted to purchase-Guaranty Fund Certificates for the Illinois State Medical Inter Insurance Exchange—call (312) 423-4499.

**GUARANTY FUND CERTIFICATE** for Territory II, Class 3—amount $2572.00—for sale. Please contact: V. J. Kelly, M.D., Cisco Lake Road, Watersmeet, MI 49969; (906) 35B-4640.

**GUARANTY FUND CERTIFICATE,** No. 214, Illinois State Medical Inter-Insurance Exchange. Contact James R. Hastings, Executor, Estate of James W. Hastings, M.D., 301 NW 2nd Street, Aledo, Illinois 61231. Phone 309-582-5388.

**GUARANTY FUND CERTIFICATE** for sale: Class 5, territory II for $1,000,000/$1,000,000 coverage, purchase price $6,024.00. For sale for $4,500.00. For information call (816) 364-5255, or write to Professional Anesthesia Services, Inc., 416 North Seventh, St. Joseph, MO 64501.

**WANTED TO PURCHASE**—Guaranty Fund Certificate—Class VI—Illinois State Medical Inter-Insurance Exchange. Please contact Mrs. Yost—(312) 596-7070.

**ILLINOIS STATE MEDICAL** Inter-Insurance Exchange Guaranty Fund Certificate for sale. Territory 1, Class 2. Original price $980.00. Best offer. Contact: Mrs. Berger (312) 272-0724.

**GUARANTY FUND CERTIFICATE,** original price $3,096.00, will discount, call 312-226-3742.

**I.S.M.S. GUARANTY FUND** ($6840.00) Certificate discounted for sale. Class 4, territory 1, number 7340, $1,000,000.00/$1,000,000.00. Sale price: $5130.00. Contact Sandra (312) 442-6500 Ex 233.

**$6,840.00 GUARANTY FUND CERTIFICATE** available at discount price through Surgeon's widow, Bonnie Kale, 312-246-1539 or Attorney, Paul Gerbosi, 346-7800.

**FOR SALE** Guaranty Fund Certificate (#4156), G.P. Class 4, original cost $3100. Contact T. C. Rozema, M.D., 1000 Rutherford Road, Landrum, South Carolina 29356; phone (803) 457-4141. No reasonable offer refused.

**GUARANTY FUND CERTIFICATE:** Class 3, $100,000/300,000, original price $2,320. Best offer. Call (206) 821-0441.

**GUARANTY FUND CERTIFICATE** issued by the Illinois State Medical Inter-Insurance Exchange for sale. 100,000/300,000, Class 1, Terr. 1. Cost 1977, one thousand thirty-two dollars. ($1032.00). Discount price. Available immediately contact Mrs. Ruth at 326-1615.

**GUARANTY FUND CERTIFICATE:** anesthesiologist class V, territory II, 1 mil/ 1 mil coverage. Originally $6024, will sell for $4800. Moving out of state. Contact Jack Friedman, M.D., 1400 West Park St., Urbana, Ill. 61B01 or call (217) 337-2140.

**ILLINOIS STATE MEDICAL INTER-INSURANCE EXCHANGE** Guaranty Fund Certificate for sale. Territory 1 Class 1. Purchase price $772. Best offer. Contact Dr. Moran at (312) 425-B000 Ext. 5566.

**WILL BUY** Guaranty Fund Certificate, Illinois State Medical Inter-Insurance Exchange, from retiring or departing physician. Contact Mrs. Yost (312) 596-7070.

*IMJ and ISMS are not acting as brokers or agents; this is provided as a membership service.*

# *EKG*

*(Continued from page 188)*

**Answers: 1. A.D.E. 2. A.B.**

This long lead II rhythm strip shows frequent premature atrial beats: in line 1 beats 4 and 14, in line 2, beat 8 and in line 3, beat 7. After each premature atrial beat the QRS becomes taller. Each time this occurs there are two or three such beats followed by a long run of beats with a deep S wave. The cycle following the premature atrial beat is longer, measuring approximately 700 msec., while the sinus rate is almost 100 beats per minute or a cycle length of 600 msec. This lengthening of the R-R cycle following the premature atrial beat allows recovery of some distal conduction tissue. The beats with the deep S wave occur at a faster rate and are leftward in their QRS axis. This suggests cycle dependent left anterior hemiblock or left axis deviation that occurs at relatively shorter cycle lengths. Notice that the QRS duration of these leftward beats is slightly longer than the QRS of the tall beats, *i.e.*, increasing from 0.06 seconds to 0.08 seconds. This would also be in keeping with left anterior hemiblock. The significance of premature atrial beats is what they may lead to, *e.g.*, atrial tachycardia, atrial flutter, or atrial fibrillation. When seen in congestive heart failure, they may disappear with digitalis treatment. Our patient was digitalized before his heart surgery so additional digitalis was administered. When this failed to prevent the premature atrial beats or a short bout of atrial fibrillation, quanidine was added. At slower heart rates, the QRS axis shifted to a normal range of +60°.


# INDEX TO ADVERTISERS

## Pharmaceuticals

| | |
|---|---|
| 181-184 | **Boehringer Ingelheim**<br>*Catapres* |
| 191 | **Burroughs Wellcome Co.**<br>*Cardilate* |
| Cover 2 | **Burroughs Wellcome Co.**<br>*Neosporin* |
| 196 | **Jobst Laboratories**<br>*Breast Prostheses* |
| 193-194 | **Mead Johnson Pharmaceutical Div'n.**<br>*Quibron*<br>*Colace* |
| 179-180 | **Roche Laboratories**<br>**Div. of Hoffman-LaRoche**<br>*Librax* |
| Covers 3-4 | **Roche Laboratories**<br>**Div. of Hoffman-LaRoche**<br>*Librium* |
| 186-187 | **Schering Corporation**<br>*Optimine* |
| 189 | **Smith Kline and French Labs.**<br>**Div. of SmithKline Corp.**<br>*Dyazide* |
| 202 | **Upjohn Pharmaceuticals**<br>*Tolinase* |

## Insurance

| | |
|---|---|
| 199 | **Medical Protective Co.**<br>*Professional Liability Ins.* |
| 325 | **Parker Aleshire and Co.**<br>*Group Insurance* |

## Services and Continuing Education

| | |
|---|---|
| 175-176 | **Blue Cross and Blue Shield Report** |
| 326 | **Classified Advertising** |
| 319 | **Cook County Graduate School**<br>*Continuing Medical Education* |
| 323 | **Crutcher Antique Show** |
| 197 | **Illinois Bell Telephone Company** |
| 200 | **Illinois Council on Continuing Medical Education** |
| 290-294 | **Illinois Medical Political Action Committee** |
| 195 | **INTRAV**<br>*African Adventure* |
| 190 | **S-Tek**<br>*Data Systems* |
| 315 | **U.S. Air Force**<br>*Recruitment* |

*Our advertisers serve the Medical Profession and support your Journal. All advertisers are approved by your Journal Committee. It will help you and your society to mention your Journal when writing them.*

*Space Representatives:* United Media Associates, Inc., 16 Bruce Park Avenue, Greenwich, Conn. 06830

# Librium®
## chlordiazepoxide HCl/Roche




- ☐ Proven antianxiety performance
- ☐ An unsurpassed safety record
- ☐ Predictable patient response
- ☐ Minimal effect on mental acuity at recommended doses
- ☐ Minimal interference with many primary medications, such as antacids, anticholinergics, diuretics, cardiac glycosides and antihypertensive agents

**Before prescribing, please consult complete product information, a summary of which follows:**

**Indications:** Relief of anxiety and tension occurring alone or accompanying various disease states. Efficacy beyond four months not established by systematic clinical studies. Periodic reassessment of therapy recommended.

**Contraindications:** Patients with known hypersensitivity to the drug.

**Warnings:** Warn patients that mental and/or physical abilities required for tasks such as driving or operating machinery may be impaired, as may be mental alertness in children, and that concomitant use with alcohol or CNS depressants may have an additive effect. Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported.

**Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

**Precautions:** In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

**Adverse Reactions:** Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

**Usual Daily Dosage:** Individualize for maximum beneficial effects. Oral—Adults: Mild and moderate anxiety and tension, 5 or 10 mg t.i.d. or q.i.d.; severe states, 20 or 25 mg t.i.d. or q.i.d. Geriatric patients: 5 mg b.i.d. to q.i.d. (See Precautions.)

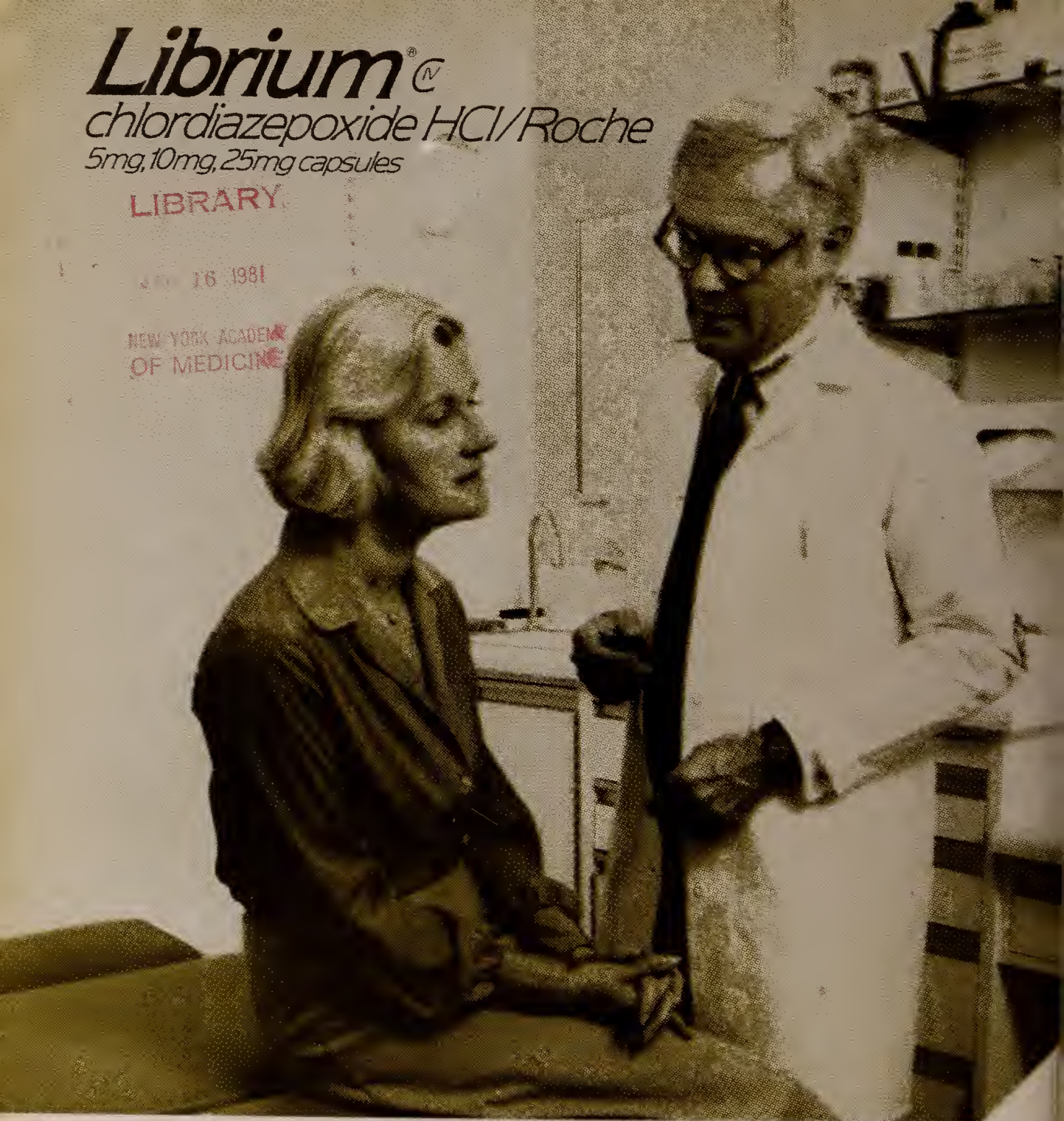
**Supplied:** Librium® (chlordiazepoxide HCl) Capsules, 5 mg, 10 mg and 25 mg—bottles of 100 and 500; Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10; Prescription Paks of 50, available singly and in trays of 10. Libritabs® (chlordiazepoxide) Tablets, 5 mg, 10 mg and 25 mg—bottles of 100 and 500. With respect to clinical activity, capsules and tablets are indistinguishable.

# synonymous with relief of anxiety

ROCHE

Roche Products Inc.
Manati, Puerto Rico 00701

**Please see following page.**




LIBRARY
16 1981
NEW YORK ACADEMY OF MEDICINE

synonymous with relief of anxiet

ROCHE

Please see preceding page for a summary of product information.

BALCONY

IMJ

# Illinois Medical Journal

OFFICIAL JOURNAL OF THE
ILLINOIS STATE MEDICAL SOCIETY

Volume 154, No. 5, November, 1978

Disseminated Gonococcal Infection: Penicillin Responsiveness As An Aid In Differential Diagnosis...343

Screening For Alcoholism: Common Warning Signs...348

A More Physiologic Skin Prep: Preliminary Report...352

President's Page...375

Table of Contents...329



# EMPIRIN® COMPOUND
# with CODEINE

Each tablet contains: aspirin 325 mg, phenacetin 162 mg, caffeine 32 mg, plus codeine phosphate in one of the following strengths: #4—60 mg (gr 1) #3—30 mg (gr ½), #2—15 mg (gr ¼) and #1—7.5 mg (gr ⅛). (Warning—may be habit forming.)

C III

Burroughs Wellcome Co.
Research Triangle Park
North Carolina 27709

IMJ

Illinois Medical Journal

NOVEMBER, 1978 Vol. 154, No. 5 CONTENTS

## Clinical Articles

343 Disseminated Gonococcal Infection: Penicillin Responsiveness As An Aid in Differential Diagnosis
*By Eugene B. Loftin, M.D., Kenneth P. Crane, M.D., and William Arnold, M.D.*

348 Screening For Alcoholism
*By Lee Spalt, M.D.*

352 Preliminary Report: A More Physiologic Skin Prep
*By Hugh A. Johnson, M.D. and Larry D. Edwards, M.D.*

## Case Reports

356 Sudden Paraplegia Caused By An Intraspinal Schwannoma
*By James B. Mansfield, M.D.*

358 Factitial Panniculitis
*By Valee Harisdangkul, M.D., Michael H. Ellman, M.D., Bruce Bennin, M.D., and David E. Fretzin, M.D.*

## Surgical Grand Rounds

361 Case Report: Branchial Cleft Cyst
*John M. Beal, M.D., Contributing Editor*

## Seminars in Immunopathology and Oncology

*Richard J. Ablin, M.D., Contributing Editor*

366 Immune Complexes and Human Disease: Part Three
*By Brian S. Andrews, BSc(Med) and Ronald Penny, M.D.*

## President's Page

375 Disapprove Concept, Not Method
*David S. Fox, M.D.*

*(Contents continued on overleaf)*

## *Features*


| | |
|---|---|
| 332 | Clinics for Crippled Children |
| 332 | Obituaries |
| 336 | EKG of the Month |
| 338 | Student Business Session |
| 364 | ISMS Guide to Continuing Medical Education |
| 370 | Physician Recruitment |
| 373 | Doctor's News |
| 376 | Classified Advertising |
| 378 | Illinois Society, American Association of Medical Assistants |
| 381 | Housestaff News |
| 383 | Pulse of the ISMS Auxiliary |


## *Staff*


**Managing Editor** ..... **Richard A. Ott**
**Assistant Editor** ..... **Mariann M. Stephens**
**Executive Administrator** ..... **Roger N. White**

*(Cover by Alicia Albanese Kolton)*

### PUBLICATIONS COMMITTEE

Herschel Browns, M.D., Chicago, *Chairman*
Kenneth A. Hurst, M.D., Naperville
Robert P. Johnson, M.D., Springfield
Alfred J. Kiessel, M.D., Decatur
Harold J. Lasky, M.D., Chicago

### Editorial Board

J. William Roddick, Jr., M.D., Springfield, *Chairman*
Eli L. Borkon, M.D., Carbondale
Daniel R. Cunningham, M.D., Wilmette
Raymond A. Dieter, Jr., M.D., Glen Ellyn
James G. Ekeberg, M.D., Palatine
Ediz Z. Ezdinli, M.D., Kenilworth
Carl Neuhoff, M.D., Peoria
Constantine S. Soter, M.D., Arlington Heights
Donald D. VanFossan, M.D., Springfield

Contributor in Surgery: John M. Beal, M.D., Chicago
Contributor in Maternal Death Studies: Robert R. Hartman, M.D., Jacksonville
Contributor in Pediatric Perplexities: Ruth Andrea Seeler, M.D., Chicago
Contributor in Radiology: Leon Love, M.D., Maywood
Contributor in Cardiology: John R. Tobin, M.D., Maywood
Contributor in Immunopathology: Richard J. Ablin, Ph.D., Chicago
Contributor in Rheumatology: L. F. Layfer, M.D., Chicago

### ILLINOIS STATE MEDICAL SOCIETY

#### OFFICERS

David S. Fox, M.D., President
826 E. 61st St., Chicago 60637
P. John Seward, M.D., President-Elect
310 N. Wyman St., Rockford 61101
Herschel Browns, M.D., 1st Vice-President
4600 N. Ravenswood, Chicago 60640
G. W. Giebelhausen, M.D., 2nd Vice-President
1101 Main St., Peoria 61606
Audley F. Connor, Jr., M.D., Secretary-Treasurer
7531 S. Stony Island Ave., Chicago 60649

#### HOUSE OF DELEGATES

Cyril C. Wiggishoff, M.D., Speaker
25 E. Washington, Chicago 60602
Robert P. Johnson, M.D., Vice-Speaker
108 Maple Grove, Springfield 62707

#### TRUSTEES

1st District: 1980, John J. Ring, M.D.
511 Hawley, Mundelein 60060
2nd District: 1980, Allan L. Goslin, M.D.
712 N. Bloomington, Streator 61364
3rd District: 1979, Alfred Clementi, M.D.
675 W. Central Rd., Arlington Heights 60005
3rd District: 1980, Raymond J. Des Rosiers, M.D.
1044 N. Francisco, Chicago 60622
3rd District: 1979, Robert T. Fox, M.D.
2136 Robincrest, Glenview 60025
3rd District, 1979, Jere Freidheim, M.D.
3050 S. Wallace, Chicago 60616
3rd District: 1981, Morris T. Friedell, M.D.
7531 S. Stony Island Ave., Chicago 60649
3rd District: 1981, Henrietta Herbolsheimer, M.D.
1700 E. 56th St., Chicago 60637
3rd District: 1981, Lawrence L. Hirsch, M.D.
2434 Grace St., Chicago 60618
3rd District: 1980, Harold J. Lasky, M.D.
55 E. Washington, Chicago 60602
3rd District: 1980, Richard N. Rovner, M.D.
645 N. Michigan, Suite 920, Chicago 60611
3rd District: 1980, Joseph C. Sherrick, M.D.
303 E. Superior, Chicago 60611
4th District: 1979, Fred Z. White, M.D.
723 N. Second St., Chillicothe 61523
5th District: 1979, P. F. Mahon, M.D.
800 E. Carpenter, Springfield 62702
6th District: 1981, Robert R. Hartman, M.D.
1515 A. W. Walnut, Jacksonville 62650
7th District: 1979, Alfred J. Kiessel, M.D.
1 Powers Lane Pl., Decatur 62522
8th District: 1979, James Laidlaw, M.D.
104 W. Clark, Champaign 61820
9th District: 1981, Warren D. Tuttle, M.D.
203 N. Vine St., Harrisburg 62946
10th District: 1981, Julian W. Buser, M.D.
6600 W. Main St., Belleville 62223
11th District: 1980, Kenneth A. Hurst, M.D.
52 Bunting Lane, Naperville 60540
12th District: 1980, Joseph Perez, M.D.
5670 E. State St., Rockford 61108
Trustee-At-Large: George T. Wilkins, M.D.
27 Glen Echo Dr., Edwardsville 62025
Chairman of the Board: Robert R. Hartman, M.D.
1515 A. W. Walnut, Jacksonville 62650



Microfilm copies of current as well as some back issues of the *Illinois Medical Journal* may be purchased from Xerox University Microfilm, 300 North Zeeh Road, Ann Arbor, Mich. 48106.

Contents of *IMJ* are listed in the *Current Contents/Clinical Practice.*

Published by the Illinois State Medical Society, 55 E. Monroe St., Chicago, Ill. 60603 (312-782-1654)



Copyright, 1978. The Illinois State Medical Society. All material subject to this copyright may be photocopied for the noncommercial purpose of scientific or educational advancement.



Subscription $8.00 per year, in advance, postage prepaid, for the United States, Cuba, Puerto Rico, Philippine Islands and Mexico. $10.00 per year for all foreign countries included in the Universal Postal Union. Canada $8.50. U.S. Single current copies available at $1.00 ($1.10 by mail), back issues $1.50.

Second class postage paid at Chicago, Ill. When moving please notify Journal office of new address including old mailing label with notification, if possible. POSTMASTER: Send notice on form No. 3579 to Illinois State Medical Society, 55 E. Monroe St., Chicago, Ill. 60603.

Pharmaceutical advertising must be approved by the ISMS Publications Committee. Other advertising accepted after review by Publications Committee or Board of Trustees. All copy or plates must reach the Journal office by the fifteenth of the month preceding publication. Rates furnished upon request.

Original articles will be considered for publication with the understanding that they are contributed only to the *Illinois Medical Journal.* The ISMS denies responsibility for opinions and statements expressed by authors or in excerpts, other than editorial or allied views or statements which reflect the authoritative action of the ISMS or of reports on official actions, policies or positions. Views expressed by authors do not necessarily represent those of the Society; any connection with official policies is coincidental.

The *Illinois Medical Journal* is published by the Illinois State Medical Society as an educational and professional informational magazine and distributed as a benefit of membership in the Illinois State Medical Society. Its intent is to keep members current in medical knowledge and is a part of a continuing medical education program. Socioeconomic matters, affecting as they do a changing pattern in the proper delivery of medical care, are considered an inherent element in medical education.

# PERFORMANCE. PROVEN EFFECTIVENESS WITHIN A WIDE SAFETY MARGIN.




While Roche Laboratories already knows more about the performance of Librium than anyone else, we keep on learning every day.

For example, the highly favorable benefits-to-risk ratio of Librium is a well-documented matter of record.

And, of course, the specific calming action of Librium has been demonstrated in millions of patients around the world. In a large number of these patients, Librium was used concomitantly with other primary medications.

Proven performance within a wide safety margin. Basically, that's what Librium is all about.

# LIBRIUM® Ⓘ℞

## chlordiazepoxide HCl/Roche

## THE ANXIETY-SPECIFIC

**Before prescribing, please consult complete product information, a summary of which follows:**

**Indications:** Relief of anxiety and tension occurring alone or accompanying various disease states. Efficacy beyond four months not established by systematic clinical studies. Periodic reassessment of therapy recommended.

**Contraindications:** Patients with known hypersensitivity to the drug.

**Warnings:** Warn patients that mental and/or physical abilities required for tasks such as driving or operating machinery may be impaired, as may be mental alertness in children, and that concomitant use with alcohol or CNS depressants may have an additive effect. Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported.

*Usage in Pregnancy:* **Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

**Precautions:** In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

**Adverse Reactions:** Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

**Supplied:** Librium® Capsules containing 5 mg, 10 mg or 25 mg chlordiazepoxide HCl. Libritabs® Tablets containing 5 mg, 10 mg or 25 mg chlordiazepoxide.

ROCHE

Roche Products Inc.
Manati, Puerto Rico 00701

# *Obituaries*

°Bordenave, Joseph L., Geneva, died September 29, 1978. Chairman of the ISMS Board of Trustees in 1975-76, Doctor Bordenave was active in many ISMS services and community activities. Doctor Bordenave, chairman of the Illinois State Medical Insurance Services Board of Directors from March, 1976 to April, 1978, was a past president of the Kane County Medical Society and also a past president of the medical staff at Community Hospital in Geneva. He had served as medical director for the Community Physicians Emergency Group.

°°Carlstrom, Fred J., Rockford, died September 15, 1978 at the age of 88. Dr. Carlstrom was a 1926 graduate of St. Louis University. During his career he was an educator at St. Anthony's School of Nursing and was appointed head of the outpatient emergency services department at Swedish American Hospital.

°Crane, Thomas P., Dwight, died September 9, 1978 at the age of 72. Doctor Crane was former superintendent of the William W. Fox Developmental Center in Dwight.

°Czajkowski, Stephen, Chicago, died September 30, 1978.

°Friskey, Roger W., Evanston, died September 12, 1978 at the age of 54. Dr. Friskey was a 1950 graduate of Northwestern University, where he served as an associate professor of medicine. He was also an assistant medical director for Standard Oil of Indiana.

°°Lyons, Mary M., Highland Park, died September 8, 1978. Dr. Lyons was a 1913 graduate of Bennett Medical College.

°Martens, Edward J., Elgin, died September 30, 1978. Dr. Martens was a 1942 graduate of the Chicago Medical School.

°Muraskas, Edward B., Oak Lawn, died September 30, 1978 at the age of 57. Dr. Muraskas was a 1945 graduate of Loyola University Stritch School of Medicine.

°Odegaard, John Arden, Elmhurst, died September 29, 1978 at the age of 57. Dr. Odegaard was a 1945 graduate of Northwestern University who served on the staff of Memorial Hospital of Dupage County for 28 years. Prior to his death he served on the staff of Passavant and Cook County Hospitals and was associated with the Chicago Medical School.

°°Pomrenze, Herman M., Chicago, died October 6, 1978. Dr. Pomrenze was a 1918 graduate of Loyola University Stritch School of Medicine.

°Ortiz, Rafael, Chicago, died February 4, 1978. Dr. Ortiz was a 1960 graduate of University of Havana.

°Swastek, Edward J., Chicago, died September 17, 1978 at the age of 71. Dr. Swastek was a 1933 graduate of Loyola University Stritch School of Medicine.

°Tamas, Marie P., Chicago, died October 1, 1978 at the age of 76. Dr. Tamas was a 1930 graduate of the Medical School of Wien Austria.

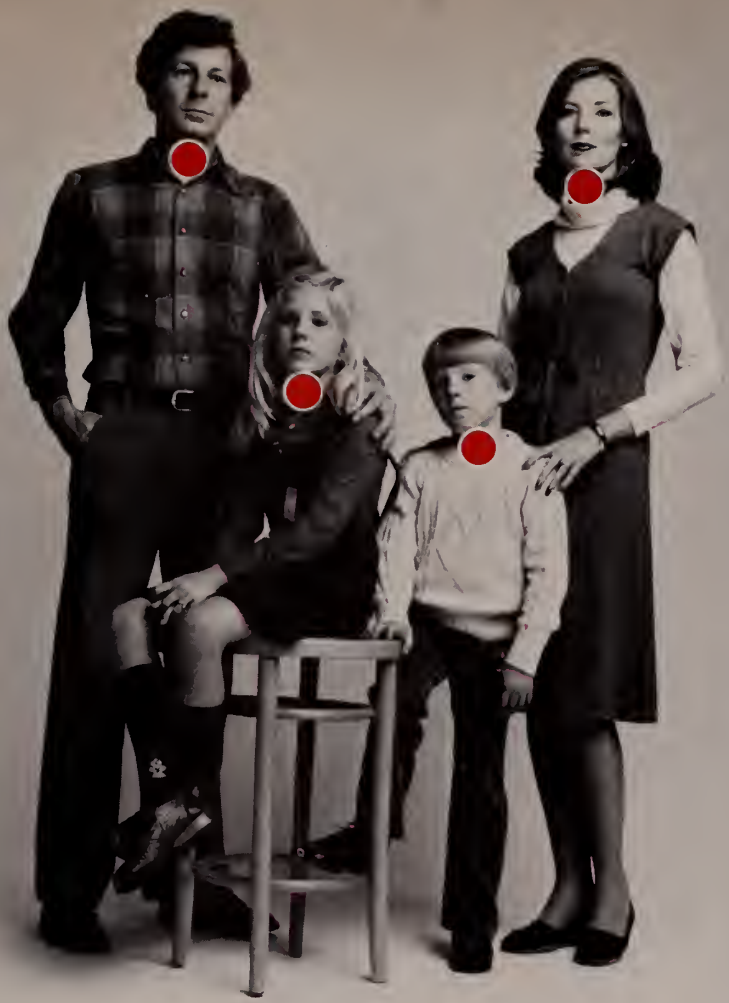
°*Indicates ISMS member.*
°°*Indicates member of the ISMS Fifty Year Club.*

# Clinics for Crippled Children Listed for December

Thirty-three clinics for Illinois' physically handicapped children have been scheduled for December by the University of Illinois, Division of Services for Crippled Children. The Division will count twenty-two general clinics providing diagnostic orthopedic, pediatric, speech and hearing examination, along with medical, social and nursing services. There will be nine special clinics for children with cardiac conditions and two for children with cerebral palsy. Any private physician may refer to or bring to a convenient clinic any child or children for whom he may want examination or consultative services.

| | | |
|---|---|---|
| December | 1 | Division Cardiac—U. of I. at the Medical Center |
| December | 5 | Park Ridge Cardiac—Lutheran Gen. Hosp. |
| December | 6 | Rock Island Cerebral Palsy—Foundation for Crippled Children and Adults |
| December | 6 | Hinsdale—Hinsdale Sanitarium |
| December | 7 | Effingham—St. Anthony Mem. Hospital |
| December | 7 | West Frankfort—Union Hospital |
| December | 7 | Litchfield—St. Francis Hospital |
| December | 7 | Sterling—Community General Hospital |
| December | 7 | Lake County Cardiac—Victory Mem. Hosp. |
| December | 8 | Chicago Heights Cardiac—St. James Hosp. |
| December | 11 | Peoria Cardiac—St. Francis Hospital |
| December | 12 | Peoria—St. Francis Hospital |
| December | 12 | East St. Louis—Christian Welfare Hosp. |
| December | 13 | Carmi—Carmi Township Hospital |
| December | 13 | Rockford—St. Anthony's Hospital |
| December | 13 | Springfield Ped-Neuro—St. John's Hosp. |
| December | 13 | Champaign—McKinley Hospital |
| December | 13 | Joliet—St. Joseph's Hospital |
| December | 13 | Aurora—St. Joseph Mercy Hospital |
| December | 14 | Springfield—St. John's Hospital |
| December | 14 | Kankakee General—St. Mary's Hospital |
| December | 15 | Evanston—St. Francis Hospital |
| December | 15 | Kankakee Cardiac—St. Mary's Hospital |
| December | 15 | Chicago Heights Cardiac—St. James Hospital |
| December | 18 | Peoria Cardiac—St. Francis Hospital |
| December | 18 | Maywood—Loyola Medical Center |
| December | 19 | Peoria—St. Francis Hospital |
| December | 19 | Rock Island—Moline Public Hospital |
| December | 19 | Belleville—St. Elizabeth's Hospital |
| December | 20 | Chicago Heights Gen.—St. James Hosp. |
| December | 21 | Rockford—Rockford Memorial Hospital |
| December | 21 | Bloomington—Mennonite Hospital |
| December | 21 | Elmhurst Cardiac—Memorial Hospital of DuPage County |

The Division of Services for Crippled Children is the official state agency established to provide medical, surgical, corrective and other services and facilities for diagnosis, hospitalization and after-care for children with crippling conditions or who are suffering from conditions that may lead to crippling. In carrying on its program, the Division works cooperatively with local medical societies, hospitals, the Illinois Children's Hospital-School, civic and fraternal clubs, visiting nurse associations, local social and welfare agencies, local chapters of the National Foundation and other interested groups. In all cases, the work of the Division is intended to extend and supplement, not supplant, activities of other agencies, either public or private, state or local, carried on in behalf of crippled children.



# Is it strep?
# Isocult® answers on the spot.

The 'Isocult' in-office culture test for throat streptococci identifies beta strep in 24 to 48 hours, so you can start treatment promptly.

In addition it indicates the possibility that antibiotic therapy should be continued for 10 days. Alerts you to the need to culture specimens from other family members. And provides a basis for follow-up culture in 14 days to test for cure.

**Simple. Reliable. And efficient.** The 'Isocult' exclusive Selec-strep® culture medium inhibits growth of most non-streptococcal throat organisms. Office personnel can read results easily by simple color-comparison with the 'Isocult' Organism Identification Chart.

And you can cover the cost of professional time while providing your patients with a savings over standard laboratory culture fees.

**Is it bacteriuria? 'Isocult' answers on the spot.** The 'Isocult' culture test for bacteriuria (like the 8 other in-office 'Isocult' tests) is reliable, rapid, inexpensive and easy to interpret (results are available within 18-24 hours). All tests are conveniently packaged for office storage. And competitively priced.

**For more information, or to order, call toll free: (800) 538-1581.**
(In California, call the number below, collect.)

*'Isocult' is available through local distributors, nationwide.*

SKD
a SmithKline company

**SmithKline Diagnostics**
880 West Maude Avenue, P.O. Box 1947, Sunnyvale, CA 94086 • (408) 732-6000




Copyright ©1978, Schering Corporation. All rights reserved

Schering

## A unique clinical option... from Schering allergy research

# Optimine® 1 mg. tablets

brand of

# azatadine maleate

### Long-acting antihistamine relief

B.I.D.dosage provides sustained symptomatic relief for up to 24 hours. Helps to keep patients adequately controlled

Prolonged duration of antihistamine action is inherent in the molecular structure...not due to tablet coatings or other slow release processes

### B.I.D. effectiveness

Patients can fit OPTIMINE into morning and evening routines...no need to carry medication. The easy-to-titrate, scored 1 mg. tablet permits dosage flexibility to meet individual patient requirements

### No dyes

Contains no sensitizing dyes with their potential for causing allergic reactions

**Optimine** A practical antihistamine to help allergy patients stay on therapy

**CONTRAINDICATIONS** Use in Newborn or Premature Infants. This drug should not be used in newborn or premature infants.

Use in Nursing Mothers. Because of the higher risk of antihistamines for infants generally and for newborns and prematures in particular, antihistamine therapy is contraindicated in nursing mothers.

Use in Lower Respiratory Disease. Antihistamines should NOT be used to treat lower respiratory tract symptoms including asthma.

Antihistamines are also contraindicated in the following conditions: hypersensitivity to azatadine maleate and other antihistamines of similar chemical structure; monoamine oxidase inhibitor therapy (See DRUG INTERACTIONS Section).

**WARNINGS** Antihistamines should be used with considerable caution in patients with: narrow angle glaucoma, stenosing peptic ulcer, pyloroduodenal obstruction, symptomatic prostatic hypertrophy, bladder neck obstruction.

Use in Children: In infants and children especially, antihistamines in overdosage may cause hallucinations, convulsions, or death.

As in adults, antihistamines may diminish mental alertness in children. In the young child, particularly, they may produce excitation.

OPTIMINE TABLETS ARE NOT INTENDED FOR USE IN CHILDREN UNDER 12 YEARS OF AGE.

Use in Pregnancy: Experience with this drug in pregnant women is inadequate to determine whether there exists a potential for harm to the developing fetus.

Use with CNS Depressants. Azatadine maleate has additive effects with alcohol and other CNS depressants (hypnotics, sedatives, tranquilizers, etc.).

Use in Activities Requiring Mental Alertness. Patients should be warned about engaging in activities requiring mental alertness, such as driving a car or operating appliances, machinery, etc.

Use in the Elderly (approximately 60 years or older): Antihistamines are more likely to cause dizziness, sedation, and hypotension in elderly patients.

**PRECAUTIONS** Azatadine maleate has an atropine-like action and, therefore, should be used with caution in patients with: a history of bronchial asthma, increased intraocular pressure, hyperthyroidism, cardiovascular disease, hypertension.

**DRUG INTERACTIONS** MAO inhibitors prolong and intensify the anticholinergic (drying) effects of antihistamines.

**ADVERSE REACTIONS** The most frequent adverse reactions are underlined.

*General*: Urticaria, drug rash, anaphylactic shock, photosensitivity, excessive perspiration, chills, dryness of mouth, nose, and throat.

*Cardiovascular System*: Hypotension, headache, palpitations, tachycardia, extrasystoles.

*Hematologic System*: Hemolytic anemia, thrombocytopenia, agranulocytosis.

*Nervous System*: Sedation, sleepiness, dizziness, disturbed coordination, fatigue, confusion, restlessness, excitation, nervousness, tremor, irritability, insomnia, euphoria, paresthesias, blurred vision, diplopia, vertigo, tinnitus, acute labyrinthitis, hysteria, neuritis, convulsions.

*Gastrointestinal System*: Epigastric distress, anorexia, nausea, vomiting, diarrhea, constipation.

*Genitourinary System*: Urinary frequency, difficult urination, urinary retention, early menses.

*Respiratory System*: Thickening of bronchial secretions, tightness of chest and wheezing, nasal stuffiness.

**OVERDOSAGE** Antihistamine overdosage reactions may vary from central nervous system depression to stimulation. Stimulation is particularly likely in children. Atropine-like signs and symptoms (dry mouth, fixed, dilated pupils, flushing, and gastrointestinal symptoms) may also occur.

If vomiting has not occurred spontaneously, the patient should be induced to vomit. This is best done by having him drink a glass of water or milk after which he should be made to gag. Precautions against aspiration must be taken, especially in infants and children.

If vomiting is unsuccessful, gastric lavage is indicated within three hours after ingestion and even later if large amounts of milk or cream were given beforehand. Isotonic and hypotonic saline is the lavage solution of choice.

Saline cathartics, such as milk of magnesia, draw water into the bowel by osmosis and therefore are valuable for their action in rapid dilution of bowel content.

Stimulants should not be used.

Vasopressors may be used to treat hypotension.

FEBRUARY 1977 11055010

For more complete details, consult package insert or Schering literature available from your Schering Representative or Professional Services Department, Schering Corporation, Kenilworth, New Jersey 07033.

Schering Schering Corporation Kenilworth, New Jersey 07033

8202-0000R

# ekg of the month

John F. Moran, M.S., M.D., David J. Hale, M.D.,
Patrick J. Scanlon, M.D., Sarah A. Johnson, M.D.,
John R. Tobin, M.S., M.D., and Rolf M. Gunnar, M.S., M.D.
Section of Cardiology, Department of Medicine,
Loyola University Stritch School of Medicine

*A forty-five year old man presented to his physicians for a routine examination. He planned to begin a jogging program to improve his physical work capacity. He physical examination was normal and he had no present or past history of serious disease. A resting ECG was interpreted as abnormal. His physician ordered a multistage exercise test by the method of Dr. Robert Bruce. The ECG rhythm strips shown are selections from the rest period, six minutes of exercise, eleven minutes of exercise, and early recovery (REC). The patient's total duration of exercise was eleven minutes, twenty seconds, and he stopped because his legs became tired.*




**Questions:**

**1. The strips from the exercise test show:**

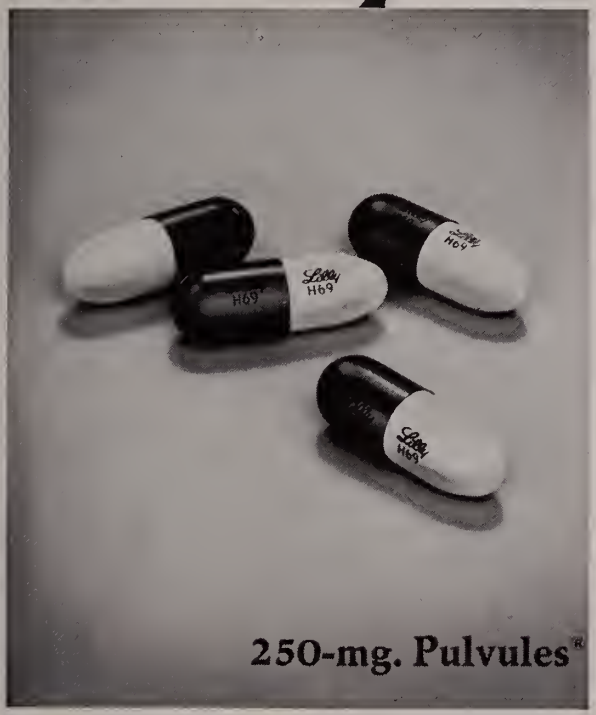
A. Abnormal ST segment depression.
B. A maximal heart rate of 130 beats per minute.
C. Premature ventricular beats in bigeminy.
D. An exercise induced intraventricular conduction defect.
E. All of the above.

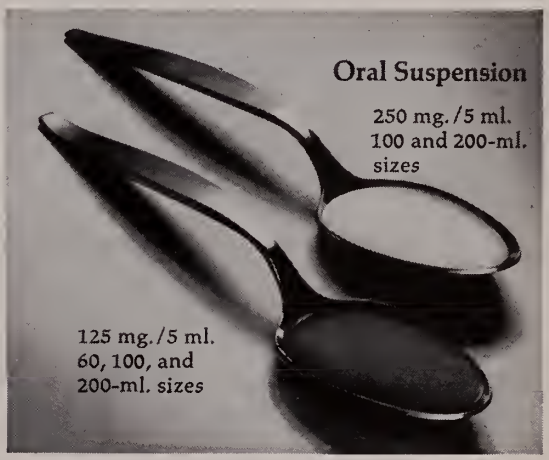
**2. Management of this patient should include:**

A. Quinidine or Procainamide in appropriate doses.
B. Propranolol and nitrates in appropriate doses.
C. Consideration of coronary arteriography.
D. Limitation of his activities, particularly vigorous jogging.
E. None of the above.

*(Continued on page 386)*

# easy to take







## Keflex®
## cephalexin

Lilly

500738

*Additional information available to the profession on request.*
Eli Lilly and Company
Indianapolis, Indiana 46206

# SBS PRESENTS

Student Business Session, Illinois State Medical Society

## "MEDICAL ASPECTS OF ALCOHOLISM"

**A program directed toward informing health professionals and students of recent developments in the diagnosis and treatment of complications of alcohol abuse.**

**and offering . . .**

***Three (3) hours of CATEGORY 2 CME CREDIT for physicians.***

## Program

### THE ACUTE CARE OF ALCOHOL WITHDRAWAL

James West, M.D., F.A.C.S., Chairman of ISMS Committee on Alcoholism and Drug Dependence, Assistant Professor of Psychiatry at Rush-Presbyterian St. Luke's School of Medicine will discuss the diagnosis and treatment of the acute alcoholic state and the subsequent four withdrawal stages.

### THE FETAL ALCOHOL SYNDROME

Donald Wayne Sellers, M.D., Director of Psychiatric Services of the Alcoholism Treatment Center at Lutheran General Hospital, and Assistant Professor of Psychiatry at Abraham Lincoln School of Medicine, will discuss the characteristic features of the child with the fetal alcohol syndrome. He will present recent data regarding the etiology of the syndrome, some of which implicates mild social drinking as a causative factor.

### UNDER-EIGHTEEN DRINKING

Donald MacLean, M.D., Assistant Professor of Psychiatry at the Rockford School of Medicine and practicing private psychiatrist will discuss the special social problems of under-18 drinking, as well as its legal implications. He will also discuss the implications of early drinking on future alcohol abuse.

**FRIDAY, DECEMBER 1, 1978 1-4 PM**
**Palmer House, South State & Monroe,**
**Chicago, Illinois**

Admission is free. The public is invited.

Blue Cross®
Blue Shield®



# REPORT FOR *Illinois Physicians*

## Health Leadership Action Program

The Chicago-based Blue Cross and Blue Shield Plan's Health Leadership Action Program—a first in the nation—is serving as a model for dozens of other corporations and health care Plans.

The goal of the HLAP is to involve community leaders in dealing with major health issues of quality, accessibility and cost containment. The program is enjoying the support throughout Illinois of business, labor, consumer, government, fraternal, educational and health organizations.

The program is built on the concept that major health care issues can best be addressed at the local level. It recognizes that needs and concerns may differ in various areas of the state.

HLAP is designed to encourage local involvement to the maximum extent, with Blue Cross and Blue Shield serving as the catalyst, resource center and coordinator.

During the year, the Health Leadership Action Program has implemented a wide range of projects, including the following:

**Action Councils.** Two local action councils were formed—one downstate and one in the Chicago suburbs. Additional councils will be formed in 1979.

**West Side Program.** A massive screening-immunization project was conducted on Chicago's West Side, serving 12,000 people in that section of the city.

**Symposium.** A major symposium was held in 1977 featuring national authorities who gave their views on the nation's health care system. The 1978 symposium, "Private Initiatives in Health Care" was held November 15 in Chicago.

**Seminars.** Quarterly seminars were held at which nationally known speakers addressed select groups of community leaders from throughout Illinois on topics of importance in the health care field.

**Educators Conference.** A conference was held for Cook County school administrators and health educators on preventive health education for school children.

**Speech Tournament.** The Land of Lincoln Speech Tournament was cosponsored with Rock Valley College. College and university students spoke on the theme of lifestyle.

**Health Fair.** In conjunction with the University of Illinois at Urbana, a two-day health fair was held on campus. A wide variety of health educational material was distributed.

**Lifestyle.** Several events, including an exercise day and canoe race were held by the Plan to emphasize the need for exercise as an integral part of good health habits.

At the heart of the Health Leadership Action Program are the action councils. The first council was formed in the fall of 1977 in a 17-county area of west-central Illinois; the second was formed in the spring of 1978 in Chicago's west suburban area.

Each council focused initially on health screening and awareness programs. Both councils conducted hypertension screening by using Blue Cross and Blue Shield's Mobile Information Centers—specially equipped mobile vans that take the programs to members' workplaces.

In addition to the screening, participants received health literature. One publication, "Your Lifestyle Profile" is a self-administered test that allows an individual to help determine his or her lifestyle condition—excellent, good, risky or hazardous.

Another pamphlet, "Change Your Mind About Your Body," addresses key lifestyle issues, such as stress, alcohol and smoking. It tells of the dangers and explains how a person can begin correcting problems and where help can be obtained.

• More than 5,000 persons were screened for hypertension since the West-Central Health Leadership Action Council was formed in Springfield in the fall of 1977.

The initial screening found that about 15 percent of the participants had elevated blood pressure that required medical attention.

• Twenty-two members of the Chicago West Suburban Health Leadership Action Council took part in its initial health screening program. Over 4,000 persons were screened for hypertension and 22,000 pieces of health literature were distributed.

• For the Chicago West Side Program, city agencies agreed to provide the necessary manpower (outreach workers, physicians, nurses and medical assistants) to perform various health tests and immunizations, and to inform the community on the program. Blue Cross and Blue Shield arranged for vans and provided clerical assistance.

Tests were conducted for lead poisoning, sickle cell anemia, hypertension, nutritional anemia, venereal disease and cervical cancer. In addition, 8,500 immunizations were given. This phase of the program was especially timely and significant because of the low level of immunizations of West Side school children.

Because of the success of the program, the Chicago Board of Health has urged Blue Cross and Blue Shield to continue the program in 1979 to areas of the city considered to be medically underserved.

*(This report is a service to the physicians of Illinois)*

## HCFA Second Opinion Surgery Program

The Department of Health, Education and Welfare has drafted the following letter for use as a newsletter regarding their second opinion surgery program:

"Health Care Service Corporation (Blue Cross-Blue Shield) is part of a nationwide program providing second opinions for elective surgery and other major medical procedures. The program is being administered by the Department of Health, Education and Welfare through its Health Care Financing Administration (HCFA). Through its Regional Office in Chicago, HCFA has designated HCSC as list holder for Cook County.

We have recently contacted physicians in this area and requested that they participate in the second opinion program. Our role as list holder will be to provide names of participating physicians to individuals calling us to request a second opinion. In addition to Medicare beneficiaries, the HEW program will cover Medicaid recipients and members of the general public.

HCSC will receive calls from individuals wanting a second opinion at 661-4252. HCSC will not call the physicians to set up an appointment for a second opinion but will simply furnish the names. More than one name will be furnished whenever possible."

A brochure has been published by HEW entitled "Facing Surgery? Why Not Get A Second Opinion?" The following topics are discussed:

*Second opinions make good medical services.*
*When you should get a second opinion.*
*Know the benefits, risks and alternatives to surgery.*
*How to find a specialist.*
*How to get a second opinion.*
*How to pay for the second opinion.*
*Often asked questions.*
*A final word about what second opinions are and what they are not.*

Copies of this brochure may be obtained by calling the Regional Office of HEW at 353-4240.

## Changes in Participation and Certification of Laboratory Procedures

Notices were received from the Medicare Bureau of the following changes in participation or in the certification of tests and procedures of laboratories in the Medicare program:

Cytotoxic Food Tests and Other Diagnostic Allergy Procedures
(Effective for Procedures Performed on and After August 1, 1978.)

Cytotoxic food tests, provocative testing, neutralization injections, intracutaneous titration, sublingual desensitization and leucocytotoxic testing are all tests employed to verify food allergies. HEW has been informed by their medical consultants that there is a lack of acceptable scientific information on the effectiveness and validity of these allergy procedures. Moreover, support of these tests by official groups of allergists has not been found.

Accordingly, cytotoxic food tests, provocative testing, neutralization injections, intracutaneous titration, sublingual desensitization and leucocytotoxic testing cannot be considered to be reasonable and necessary under Medicare law.

No program payment may be made for these allergy procedures performed on or after August 1, 1978.

**Changes in Approved Tests and Procedures:**

Island Medical Laboratory, Inc., 8452 Stony Island Ave., Chicago, Ill. 60617 (Provider Number 14-8247) has been approved to perform Procedures 300-Chemistry and 710-EKG Services, effective August 8, 1978. The laboratory is also approved to perform Procedures 110-Bacteriology; 200-Serology; 510-Blood Group and Rh Typing; 630-Diagnostic Cytology; and 400-Hematology.

Advanced Medical Laboratories, Inc., 5457 West Chicago Ave., Chicago, Ill. 60651 (Provider Number 14-8325) is no longer approved to perform Procedure 630-Diagnostic Cytology, effective October 1, 1978. The laboratory is approved to perform Procedures 110-Bacteriology; 200-Serology; 310-Chemistry Routine; 320-Clinical Microscopy; 400-Hematology; 510-Blood Group and Rh Typing.

**Closing:**

Medical Associates of Chicago, 3223 South Dr. Martin Luther King Jr. Drive, Chicago, Ill. 60616 (Provider Number 14-8080) has withdrawn from the Medicare program as an independent laboratory, effective September 1, 1978. No payment will be made by Medicare for services furnished to patients on or after that date.

# What's new at Bio-Science Chicago?



## Always the latest specialized diagnostic tests.

**Chemistry**
Anti-convulsant group
Cadmium in blood
Darvon®
Ferritin in serum
Free erythrocyte protoporphyrins
Pyridoxal phosphate ($B_6$)
Riboflavin ($B_2$)
Succinimides in serum
Theophylline
Uroporphyrinogen-1-synthetase
Clonopin®

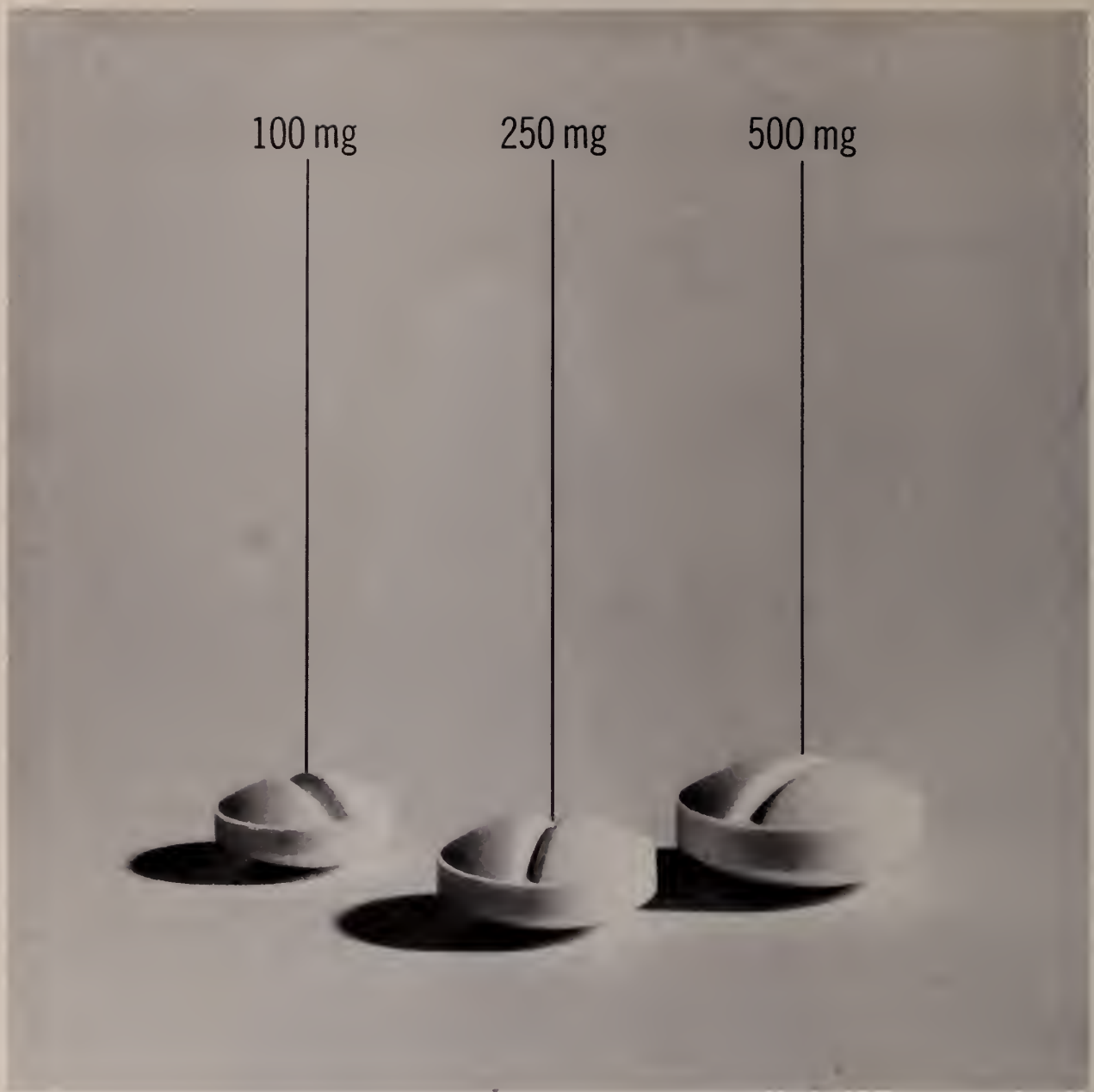
**Endocrinology**
Androstenedione in serum
Calcitonin
C-Peptide
Estriol in serum
Placental Estriol in urine
HCG-$\beta$-subunit
Pregnanetriol in urine (GLC)
Prolactin
17-OH Progesterone in serum
Thyroglobulin in serum
25-Hydroxy Vitamin D
Estradiol Receptor Assay by Scatchard Plot
Progesterone Receptor Assay

**Immunochemistry**
Anti-extractable nuclear antigen (Anti-ENA)
Fungus antibody group
Gentamicin
Intrinsic factor antibodies
Tobramycin
Anti-tissue antibodies
HLA-B27

Bio-Science

**Bio-Science Laboratories**

Chicago Branch
770 Burr Oak Drive
Westmont, Il 60559
(312) 887-9800




# Tolinase®
## tolazamide, Upjohn

Please contact your Upjohn representative for additional product information.

Upjohn

J-5695-6

©1977 THE UPJOHN COMPANY

IMJ
Illinois Medical Journal
Vol. 154, No. 5, November, 1978

## Penicillin Responsiveness As An Aid In Differential Diagnosis

# Disseminated Gonococcal Infection

By Eugene B. Loftin, III, M.D., Kenneth P. Crane, M.D., and William J. Arnold, M.D./Chicago

*Hematologically-disseminated gonococcal infection (DGI) is usually described as an acute, migratory, non-destructive polyarthritis-tenosynovitis associated with skin lesions and typically occurring in young females. Our retrospective study of fourteen patients with DGI syndrome confirms this impression. However, our study also suggests that DGI syndrome may occur frequently in males (5/14 cases) and that typical skin lesions or positive cultures for gonococcus are frequently absent (8/14), which complicates the differential diagnosis. In the latter setting our analysis indicates that following a thorough evaluation, a therapeutic trial of penicillin will always result in significant improvement after 48-96 hours in patients with the DGI syndrome and therefore, frequently supplies the correct diagnosis.*

The incidence of human infection with Neisseria gonorrhea has shown a striking increase in the United States since 1919.[1] This has been accompanied by a wider recognition of hematologically-disseminated gonococcal infection (DGI) which is manifest as an arthritis-dermatitis syndrome. This DGI syndrome was first described by Vidal in 1893 as a monoarticular destructive arthritis associated with skin lesions seen primarily in males.[2] Although initially thought to be an unusual accompaniment of N. gonorrhea infection, the DGI syndrome is estimated to occur in 1-3% of patients.[3] Additionally, the DGI syndrome is now characterized as a non-destructive poly- or monoarticular arthritis associated with fever, chills, pharyngitis, and skin lesions.[4-6]

Skin lesions may vary in appearance from small, erythematosus, non-tender macular lesions to painful, pustular lesions often with a necrotic center.[4,7] DGI diagnosis is often delayed because these clinical findings frequently occur in the absence of the classic signs and symptoms of genitourinary infection. In addition, arriving at the correct diagnosis is complicated by poor recovery of the gonococcus from synovial fluid and blood cultures. Although less than satisfactory, Garcia-Kutzback and co-workers have suggested that a prompt response to penicillin therapy may be used retrospectively

to establish the diagnosis of DGI.[8] Using this criteria we have reviewed the clinical characteristics of 14 patients with a penicillin-responsive arthritis-dermatitis syndrome seen by the rheumatology service between 1975 and 1977. Our analysis indicates that DGI may occur in both males and females and is often the presenting manifestation of N. gonorrhea infection. In addition, our experience suggests that the diagnosis of DGI is often made on a clinical rather than a laboratory basis and that penicillin responsiveness is a valuable clinical criterion.

## Materials and Methods

Fourteen patients seen by the rheumatology service at the University of Illinois and West Side Veterans Administration Hospital from 1975 to 1977 were studied by chart review. Synovial aspirate, pharynx, urethra, cervix, blood and rectum were sampled and plated at bedside on Thayer-Martin and chocolate agar plates which were then held in a candle jar. Not all suggested sites were cultured in all cases, but the majority of case evaluations included at least cultures of synovial aspirate, blood, and urethra.

On the basis of the clinical manifestations and culture results the patients were then divided into the groups suggested by Gelfand and co-workers[9] (Table I).

## Results

The typical presentation involved a young patient who was sexually active with multiple partners. These patients all sought medical assistance for pain and swelling in multiple joints. The age range for females was 17 to 42 years with a mean age of 28 years, and for males 19 to 48 years with a mean age of 32 years. None of these patients presented with a chief complaint of venereal infection. Six of 14 patients had a history of previous gonococcal infection. Five of 14 patients were married. Typical history prior to admission was a prodrome of fever often with chills (7 cases) and/or pharyngitis (4 cases) lasting 1-4 days prior to the onset of swollen painful joints. These usually included wrists (usually dorsum), metacarpophalangeal joints, ankles and knees, but occasionally also the elbows and shoulders.

The typical skin lesions were not usually mentioned by the patients but were noted on physical examination in 10 cases. All patients presented with low grade fever ranging from 99° to 103°F.[4] Physical examination also showed urethral, or vaginal discharge, or cervicitis, in 2 of 9 cases with negative synovial fluid cultures (Group Ib). The same problems were evident in the one case with positive synovial fluid culture (Group III), and 1 of 3 suspected cases (Group IV).

Of the cases where N. gonorrhea was cultured, one was from the urethra and another from the vagina (Group Ib). In addition, gram negative diplococci were seen in white cells in the synovial fluid in one case (Group Ib), but could not be cultured. In patients with positive synovial fluid cultures (Groups II and IIIa) for N. gonorrhea, the organism was not cultured from other sites. No positive cultures were obtained by definition in Group IV but gram negative intracellular diplococci were observed in the vaginal smear of one patient. No joint that was X-rayed in any case showed abnormality. Synovial fluid aspirates had WBC counts ranging from 14,000/mm$^3$ to too numerous to count (>100,000/mm$^3$).

The common denominator in all patients was the remarkable response to penicillin therapy. Typically, patients became afebrile within 24 hours after beginning penicillin therapy. Subjective and objective improvement of the articular manifestations was evident by 48 hours with marked improvement by 5 days (mean 66 hours). No new skin lesions were noted to occur after 24 hours on penicillin therapy.

## Discussion

This study supports the modern picture of DGI syndrome as an illness primarily of young, otherwise healthy individuals. In nine of our fourteen patients the DGI syndrome was characterized by an acute febrile illness associated with characteristic skin lesions and polyarthritis-tenosynovitis. This study does not support the previously reported high incidence of monoarticular disease.[4-6] Although there is no obvious reason for this discrepancy, it may be due to the organism's progressive changing character or early presentation for therapy.[9,10] In addition, this study demonstrates that the DGI syndrome is not only a disease of females but frequently involves males. Even though the population of males was primarily from the West Side Veterans Hospital, the sizeable number should still remind the clinician that this syndrome does occur in males.

The variable clinical manifestations of DGI syndrome with the frequent absence of genitourinary symptoms in our study stresses the importance of the recognition of the DGI syndrome as the initial presentation of gonococcal infection to the internist, family physician, or dermatol-

Table I
Clinical Classifications of 14 Patients
With the DGI Syndrome

| Patient Groups* | Ia | Ib | II | IIIa | IIIb | IV |
|---|---|---|---|---|---|---|
| # of Patients | None | 9 | 1 | 1 | None | 3 |
| Sex | — | 4F/5M | 1M | 1F | — | 3F |
| Marital Status | — | 2 married<br>7 other | 1 single | 1 single | — | 3 married |
| History of Previous G.C. | — | 4/9 | — | 1/1 | — | 1/3 |
| History of Discharge | — | 1/9 | — | 1/1 | — | 1/3 |
| History of Pharyngitis | — | 2/9 | — | — | — | 2/3 |
| Positive Cultures For N. Gonorrhea | — | 2/9 | 1 | 1 | — | 0/3 |
| Time to Response After Start of Antibiotic | — | 1-4 days (mean 66 hr) | 5 days | 48 hrs | — | 2-4 days (mean 72 hr) |

*Group I—Hematogenous
No cultural confirmation of gonorrhea from synovial fluid, type:
a. Positive blood cultures for N. gonorrhea
b. Typical skin lesions of gonococcal sepsis, but negative blood cultures.

Group II—Transition
Positive cultures for N. gonorrhea from synovial fluid plus positive blood cultures or typical skin lesions.

Group III—Joint Localization
Positive synovial fluid cultures for N. gonorrhea.
No skin lesions or positive blood cultures, type:
a. Polyarthritis,
b. Monoarthritis

Group IV—Suspected Cases
Suggestive clinical pattern including history, physical and X-rays.
No skin lesions or positive blood cultures.
No cultural confirmation from synovial fluid.

ogist. The differential diagnosis of this presentation is broad and includes (Table II):

1) *Other causes of infectious arthritis* should be easily differentiated by age and previous health history of patient, by blood and synovial fluid cultures, and by response to specific therapy.[11]

2) *Acute rheumatic fever* has its own characteristic rash and may be associated with myocarditis. The arthritis of acute rheumatic fever does not respond to penicillin therapy.

3) *Reiter's syndrome* is predominantly a disease of males with characteristic ocular and painless mucous membrane lesions.

4) *Immune complex disease* associated with systemic lupus erythematosus and hepatitis-associated antigen should be considered. The typical rash of DGI is absent in both. SLE may have other signs suggestive of the diagnosis and the fluorescent test for antinuclear antibodies is positive. HAA polyarthritis may closely mimic the DGI syndrome, however, the finding of antigenemia and abnormal liver enzymes readily distinguishes between the two illnesses.

5) *Henoch-Schölein purpura* is a disease primarily of children with non-pustular lesions which are more widely distributed than those seen in N. gonorrhea and involve the face.

6) *Chronic meningococcal septicemia* may clinically be identical to the DGI syndrome particularly in milder cases. The lesions of meningococcal septicemia are rarely pustular and are more widely distributed than those of N. gonorrhea.

7) *Lymphogranuloma venereum* is also associated with arthralgia and fever, but the skin

| Table II<br>Differential Diagnosis of DGI Syndrome |
|---|
| 1) Other causes of infectious arthritis |
| 2) Acute rheumatic fever |
| 3) Reiter's syndrome |
| 4) Immune complex-mediated diseases |
| 5) Henoch Schönlein purpura |
| 6) Meningococcemia |
| 7) Lymphogranuloma venereum |
| 8) Lyme arthritis |
| 9) Type B. Hemophilus influenza arthritis |
| 10) Streptobacillus moniloformis arthritis |

lesions are not pustular and the syndrome is associated with typical adenopathy not found in DGI.

8) *Lyme arthritis* is a recently described clinical entity with symptoms of fatigue, chills, fever and pharyngitis associated with monoarticular or oligoarticular arthritis sometimes following the onset of a rash which begins on the extremities as a red macule or papule (erythema chronicum migrans).[12] The main points of differentiation from the DGI syndrome are that Lyme arthritis occurs primarily in eastern Connecticut with peak incidences in summer or early fall. Cases present in clusters and the rash progresses to large annular lesions.

9) *Type B. Hemophilus influenza arthritis* usually occurs in childhood.[13] The infected synovial fluid is purulent and green-tinged. This has been described as characteristic of H. influenzal pyarthrosis.[14] Most cases occur in patients with chronic debilitating disease.

10) *Streptobacillus moniloformis arthritis* has a skin rash which is morbilliform to rubella-like.[13] No vaginal or penile discharge is present. The gram stain of synovial fluid reveals gram negative pleomorphic bacillus.

## Treatment

An approach to the patient presenting with polyarthritis of abrupt onset in whom the differential diagnosis includes the DGI syndrome should include the following:

1) Careful history for length and distribution of symptoms and for any associated infections or complaints suggestive of gonorrhea. This includes a careful sexual and menstrual history.

2) Careful physical examination for the characteristic skin lesions of gonococcemia (or the other diseases in the differential diagnosis).

3) Cultures of throat, urethra, and rectum for N. gonorrhea (tenosynovitis may also be aspirated but culture of skin lesions are usually nonproductive in DGI).

4) X-rays of affected joints.

5) Aspiration of synovial fluid for culture, routine and polarizing microscopy, gram stain, and determination of total WBC count and differential and glucose (with a simultaneous serum glucose).

6) Routine laboratory studies including CBC, urinalysis, chest X-ray, EKG, erythrocyte sedimentation rate.

7) Special laboratory studies including liver function tests, ASO titer, antinuclear antibodies and hepatitis-associated antigen and antibodies.

Once the initial data base is gathered, then a trial with intravenous penicillin (10 million units per 24 hours) should be commenced if the exact diagnosis remains unclear.[15] In our study, 90% of patients had some subjective response to penicillin within 48 hours. It is important, however, that no other agents such as analgesics or anti-inflammatory agents be given during this trial period in order not to confuse the response to antibiotics. Persistently inflammed joints should be aspirated dry once or twice daily until a response is obtained. If no response to penicillin is evident in four days, the diagnosis of the DGI syndrome is dubious and antibiotics may be discontinued (if cultures are negative).[16] At this point a thorough re-evaluation should be performed and further therapy instituted on the basis of the new data.

## Conclusion

The characteristics of the syndrome have changed, probably as a result of selective pressures from antibiotic usage and social conditions.[10] This study supports the modern picture of the DGI syndrome as a febrile illness primarily of young females or males who present with polyarthritis and characteristic skin lesions. The arthritis is non-destructive and penicillin responsive. This study also illustrates the usefulness of penicillin responsiveness as a diagnostic criterion. ◄

### References


1. American Social Health Association: Today's VD Control Problem, 1973, p. 10.
2. Vidal, Emile: "Éruption généralisée et symétrique de crôutes corneées, avec chute des ongles, d'origine belnnorrhagique, corncïdant avec une polyarthrite de même nature.—Récidiue a'la suite d'une nouvelle belnnorrhagie, duex ans après la gué rison de la premiére maladie,' *Annales de Dermatologie et de Syphiligraphie*, 3.s., iv., p. 3-11, 1893.

3. Kiesar, Harold, *et al.*, "Clinical Forms of Gonococcal Arthritis," *New Eng. J. Med.*, 279:234-240, 1968.
4. Seifert, M. H., Warin, A. P., and Miller, A.: "Articular and Cutaneous Manifestations of Gonorrhea. Review of Sixteen Cases," *Ann. Rheum. Dis.*, 33:140-145, 1974.
5. Spink, W. W. and Keefer, C. S.: "Latent Gonorrhea as a Cause of Polyarticular Arthritis," *JAMA*, 109: 325-328, 1937.
6. Partain, J. O., Cathcart, E. S. and Cohen, A. S.: "Arthritis Associated with Gonorrhea," *Ann. Rheum. Dis.*, 27:156-162, 1968.
7. Abu-Nassar, H., *et al.*, "Cutaneous Manifestations of Gonococcemia," *Arch. Int. Med.*, 112:731-737, 1963.
8. Garcia-Kutzbach, Abraham, *et al.*, "Gonococcal Arthritis: Clinical Features and Results of Penicillin Therapy," *J. of Rheum.*, 1 (2):210-221, 1974.
9. Gelfand, Stephen, *et al.*, "Spectrum of Gonococcal Arthritis: Evidence for Sequential Stages and Clinical Sub-groups," *J. of Rheum.*, 2 (1):83-90, 1974.
10. Olsen, G. A. and Lomholt, G.: "Gonorrhea Treated By a Combination of Probenicid and Sodium Penicillin G," *British Journal of Venereal Disease*, 45:144-148, 1969.
11. Garcia-Kutzback, Abraham and Masi, Al Fonse T.: "Acute Infectious Agent Arthritis (IAA): A Detailed Comparison of Proved Gonococcal and Other Blood-born Bacterial Arthritis," *J. of Rheum.*, 1 (1):93-101, 1974.
12. Steere, Allen C., *et al.*, "Erythema Chronicum Migrans and Lyme Arthritis: The Enlarging Clinical Spectrum," *Annals of Int. Med.*, 86:685-698, 1977.
13. Krauss, D. S., Anderson, M. D., Gump, D. W., and Newcombe, D. S.: "Hemophilus Influenzae Septic Arthritis," *Arthritis and Rheumatism*, 17 (3) :267-271, 1974.
14. Gump, D. W., Tarr, P., Phillips, C. A., *et al.*, "Bacterial Antibodies to Hemophilus Influenzae," *Proc. Soc. Exp. Biol. Med.*, 138:76-80, 1971.
15. Handsfield, Hunter H., *et al.*, "Treatment of Gonococcal Arthritis-Dermatitis Syndrome," *Annals of Int. Med.*, 84:661-667, 1976.
16. Wiesner, Paul, *et al.*, "Low Antibiotic Resistance of Gonococci Causing Disseminated Infection," *New Eng. J. Med.*, 288:1221-1222, 1973.

EUGENE B. LOFTIN, III, M.D., is an internist and family practitioner who was senior medical resident in the department of medicine at the UI Hospital in Chicago at this writing. Doctor Loftin is an associate member of the American College of Physicians.

KENNETH P. CRANE, M.D., was a board-certified internist and a fellow in the section of genetic and rheumatic diseases at the UI Hospital in Chicago at this writing. Doctor Crane is currently a staff physician in the rheumatology section at Lutheran General Hospital in Park Ridge.

WILLIAM J. ARNOLD, M.D., was chief of the section of genetic and rheumatic diseases at the University of Illinois Hospital at this writing. He is presently chief of the rheumatology section for Lutheran General Hospital.

**LOW-COST GROUP INSURANCE ANOTHER ISMS MEMBERSHIP PRIVILEGE**

**THE GROUP DISABILITY PLAN** ● Provides up to $1,732.00 monthly in the event of disability caused by Accident or Sickness. ● Special Guaranteed renewal feature. ● Protect your income and security.

**BUSINESS OVERHEAD EXPENSE PLAN** ● Pays your office overhead expense when disability strikes. ● Premiums are Tax Deductible. ● Pays in Addition to the Disability Plan Benefits.

**THE BASIC MAJOR MEDICAL EXPENSE PLAN** ● In or out of Hospital Benefits up to $25,000.00 per Disability. ● Up to $100.00 Daily Hospital Room and Board maximum. ● Subject to choice of deductible and 80% coinsurance.

**EXCESS MAJOR MEDICAL PLAN** ● Provides up to $500,000 for Medical Expenses. ● Supplements any Basic Major Medical Plan and is available with a $15,000, $20,000 and $25,000 deductible. Low group rates. ● Truly catastrophic coverage.

FOR INFORMATION, ASSISTANCE & DETAILS CONTACT:

Administrators:
PARKER, ALESHIRE & COMPANY
ESTABLISHED 1901
Insurance

9933 N. Lawler Avenue
Skokie, Illinois 60077
Phone: 312-679-1000

# Screening For Alcoholism

By Lee Spalt, M.D./Carbondale

*Valid, brief screening procedures for alcoholism are needed to identify that drug dependency in patients. The diagnostic criteria for psychiatric research of Feighner,* et al., *were used to diagnose alcoholism in 37 (24%) of 154 consecutively evaluated psychiatric outpatients in a university medical center general psychiatry clinic. Data analysis demonstrated that the patients' reports that either they, their families, or other cardinal persons thought they drank too much alcohol did identify all (100%) of the alcoholics. The findings supported the earlier reports of Woodruff,* et al.

*A brief screening for alcoholism using patients' reports of excessive drinking was found to be a reliable indicator for the presence of alcoholism.*

The most prevalent form of physical dependence is that produced by the drug alcohol.[1] Because of its frequency, chronicity, and social, psychological and medical complications, alcoholism is probably the single most important psychiatric public health problem in the United States.[2] Although many patients who have a history of alcoholism come to the attention of health care professionals, the alcoholism is not always recognized.[3-6]

Alcoholics Anonymous used a 36-item questionnaire for the study of certain symptoms of alcoholism. E. M. Jellinek published the findings in 1946.[7] After more elaborate study using a 111-item questionnaire, Jellinek presented new findings in 1952.[8] Recent reports have presented more manageable diagnostic criteria[6,9-11] outlined by Feighner, *et al.*[12] More recently Woodruff, *et al.*, published a brief screening method for identifying alcoholism.[13] They found that 98% of patients with histories meeting research criteria for definite alcoholism and 89% of patients with probable alcoholism were identified by the subjects' reports that they or others believed the subjects drank too much. Woodruff, *et al.*, concluded that several easily administered questions could serve as a highly reliable screening test for alcoholism.

It is hypothesized that patients' reports that they or others thought that they (the patients) drank too much alcohol identify the presence of alcoholism as adequately as more extensive symptom histories.



LEE SPALT, M.D., is a psychiatrist affiliated with the Southern Illinois University Student Health Programs. A former assaciate professar in psychalagy far SIU, Dactar Spalt is particularly interested in the epidemiologic develapment af psychiatric disorders.

## Method

Comprehensive, structured interviews covering details of the Feighner, *et al.*, diagnostic criteria for psychiatric research were uniformily adminis-

**Table 1**
**Research Criteria for a Diagnosis of Alcoholism**

**Group A**

1. Have you experienced withdrawal symptoms (shakes, convulsions, hallucinations, DT's) when you have stopped drinking alcohol?
2. Have you had medical complications (liver, stomach, pancreas, muscle or nerve problems) from drinking alcohol?
3. Have you experienced blackouts (periods of amnesia not related to head injury) when you have been drinking heavily?
4. Have you gone on drinking binges or benders (drinking for 48 or more hours with neglect of your usual duties)? More than one bender is needed to score as positive.

**Group B**

1. Have you been unable to stop when you wanted to stop drinking?
2. Have you attempted to control your drinking by allowing yourself to drink alcohol only under certain circumstances?
3. Have you drunk alcohol before breakfast?
4. Have you drunk non-beverage alcohol (hair oil, mouth wash, Sterno, etc) for its alcohol content?

**Group C**

1. Have you had arrests related to drinking alcohol?
2. Have you had traffic difficulties related to your use of alcohol?
3. Have you had trouble at work or school because of your drinking?
4. Have you had fights associated with times that you have been drinking?

**Group D**

1. Have you thought that you drink too much alcohol?
2. Has your family objected to the amout of alcohol you drink?
3. Have you lost friends because of your drinking?
4. Have persons other than your family objected to the amount of alcohol you drink?
5. Have you felt guilty about your drinking?

tered to each of the 154 patients seen for evaluation by this investigator during six consecutive months. The site was a public/semi-private psychiatric outpatient clinic attached to the Washington University School of Medicine and serving the metropolitan St. Louis, Missouri-Illinois area.

A diagnosis of definite alcoholism was made when symptoms were present in three of the four groups of symptoms outlined in Table 1. Probable alcoholism was diagnosed when symptoms were present in two of the four groups.

The study sample included both new and return patients from a variety of referral sources and was representative of the psychiatric clinic population. The significance of findings was tested by the chi-square and, when appropriate, also the Yates correction method.

## Results, Data and Discussion

Table 2 presents the frequency of symptoms of alcoholism for the present study, compares symptom frequencies for both alcoholic and nonalcoholic psychiatric patients, and compares findings of the present study with those of Woodruff, *et al.*[13] Both the Woodruff, *et al.*, study and the present study used the Feighner, *et* al., diagnostic criteria for psychiatric research to identify alcoholic patients. The present study found 37 (24%) alcoholic patients among 154 consecutively evaluated psychiatric outpatients. Woodruff, *et al.*, studied 500 probands and diagnosed 70 (14%) alcoholics.

Alcoholics interviewed in the present study more often reported attempted control (78% vs 31%) and inability to stop drinking (59% vs 36%) than in the previous study. The present study nonalcoholics also reported more attempted control (8% vs 1%) and inability to stop drinking (3% vs <1%) than the previous study nonalcoholics. Present study alcoholics less often reported that persons other than family objected to their drinking (35% vs 70%). Other symptom frequencies did not vary significantly between the two studies.

In the present study each symptom of alcoholism was reported significantly more often (at

**Table 2**
**Frequency of Symptoms of Alcoholism**

| | Alcoholics | | | | Nonalcoholics | | |
|---|---|---|---|---|---|---|---|
| | Woodruff, *et al.* | | Present Study | | Present Study | | Woodruff, *et al.* |
| N | (70) | | (37) | | (117) | | (430) |
| Symptoms | % | p | % | p | % | p | % |
| Group A. | | | | | | | |
| Withdrawal symptoms. | 40 | NS | 49 | <.0005 | — | NS | — |
| Medical complications | | NA | 22 | <.0005 | — | NA | |
| (Impotence)* | 6 | NA | | | | NA | 1 |
| Blackouts. | 66 | NS | 57 | <.0005 | 2 | NS | 2 |
| Binges or benders. | 46 | NS | 54 | <.0005 | 1 | NS | — |
| Group B. | | | | | | | |
| Unable to stop. | 36 | <.05 | 59 | <.0005 | 3 | <.005 | — |
| Attempted control. | 31 | <.0005 | 78 | <.0005 | 8 | <.0005 | 1 |
| Alcohol before breakfast. | 61 | NS | 54 | <.0005 | 2 | NS | 1 |
| Non-beverage alcohol. | 4 | NS | 3 | <.005 | — | NS | — |
| Group C. | | | | | | | |
| Alcohol related arrests. | 34 | NS | 30 | <.0005 | 2 | <.01 | — |
| Traffic difficulties. | 23 | NS | 41 | <.0005 | 1 | NS | 2 |
| Trouble at work. | 19 | NS | 24 | <.0005 | — | NS | 1 |
| Fighting. | 46 | NS | 57 | <.0005 | 3 | NS | 2 |
| Group D. | | | | | | | |
| Pt. thinks drinks too much. | 75 | NS | 81 | <.0005 | 9 | NS | 7 |
| Family objects. | 77 | NS | 78 | <.0005 | 9 | NS | 7 |
| Loss of friends. | 21 | NS | 32 | <.0005 | 1 | NS | — |
| Others object. | 70 | <.001 | 35 | <.0005 | 2 | NS | 3 |
| Pt. feels guilty. | 53 | NS | 49 | <.0005 | 3 | NS | 2 |

*Woodruff, *et al.* reported the specific medical complication of impotence.
NS = Not Significant
NA = Not Applicable

least 8 times more often) by those patients diagnosed as alcoholic ($p<.005$). As Woodruff, *et al.*, indicated, the report of excessive drinking alone adequately identified the alcoholic patients. In the present study, the report of excessive drinking alone identified all the alcoholic patients. When Woodruff, *et. al.*, used one of the three reports of excessive drinking as an indication of alcoholism, they found 9% to 11% of each nonalcoholic group were misidentified as alcoholic. In the present study a report of at least one of the three kinds of reports of excessive drinking was found in 15 (12.8%) of the nonalcoholic group. Of those 15 nonalcoholics misidentified by the three brief screening questions, 10 thought that they drank too much, 10 reported that their families objected to their drinking, and 2 indicated that other cardinal persons thought that the patients used too much alcohol.

We found the most frequently reported symptom of alcoholism to be that the patients thought themselves to drink too much alcohol (81%).

**Table 3**
**Alcoholics Identified by Report of Excessive Drinking***

| | Woodruff, *et al.* | Present Study |
|---|---|---|
| Probable Alcoholism | (N=19) | (N=1) |
| Excessive drinking reported | 89% | 100% |
| Excessive drinking not reported | 11% | — |
| Definite Alcoholism | (N=51) | (N=36) |
| Excessive drinking reported | 98% | 100% |
| Excessive drinking not reported | 2% | — |
| All Alcoholism (probable and definite combined) | (N=70) | (N=37) |
| Excessive drinking reported | 96% | 100% |
| Excessive drinking not reported | 4% | — |

*Excessive drinking was considered reported if the patient reported that the patient, a member of the patient's family, or some other cardinal person thought that the patient drank too much alcohol.

Family objection and patient attempted control were each reported by 78% of the alcoholic patients. A report of the objection of other cardinal

persons was recorded for only 35% of the alcoholic group, with eight other symptoms being reported more frequently.


### Summary

Alcoholism was present in 24% of the 154 patients interviewed. The alcoholics reported symptoms of alcoholism in frequencies compatible with previous reports, with the exceptions of more attempted control, more inability to stop, and less objection by other cardinal persons.

All (100%) of the alcoholics were identified by their report that they, their family, or others thought they used alcohol to excess. A brief screening for alcoholism using patients' reports of excessive drinking was found to be a reliable indicator for the presence of alcoholism. ◄


### References


1. Davis, V., Walsh, M.: "Alcohol, Amines, and Alkaloids: A Possible Biochemical Basis for Alcohol Addiction," *Science*, 167:1005-1006, 1970.
2. Public Health Service, National Institute of Mental Health: "Alcohol and Alcoholism," P.H.S. publication No. 1640, 1967.
3. Green, J.: "The Incidence of Alcoholism in Patients Admitted to Medical Wards of a Public Hospital," *Med. J. Aust.*, 1:465-466, 1965.
4. Nolan, J.: "Alcohol as a Factor in the Illness of University Service Patients," *Amer. J. Med. Sci.*, 249:135-142, 1965.
5. Pearson, W.: "The "Hidden" Alcoholic in the General Hospital," *N. Carolina Med. J.*, 23:6-10, 1962.
6. Barchha, R., Stewart, M., Guze, S.: "The Prevalence of Alcoholism Among General Hospital Ward Patients," *Amer. J. Psychiat.*, 125:133-136, 1968.
7. Jellinek, E.: "Phases in the Drinking History of Alcoholics: Analysis of the Survey Conducted by the Official Organ of Alcoholics Anonymous," *Quart. J. Stud. Alcohol*, 7:1-88, 1946.
8. Jellinek, E.: "The Phases of Alcohol Addiction," *Quart. J. Stud. Alcohol*, 13:673-684, 1952.
9. Jellinek, E.: THE DISEASE CONCEPT OF ALCOHOLISM, New Haven, Conn., Hillhouse Press, 1960.
10. Guze, S., Goodwin, D., Crane, B.: "Criminality and Psychiatric Disorders," *Arch. Gen. Psychiat.*, 20:583-591, 1969.
11. Bailey, M., Haberman, P., Alksne, H.: "The Epidemiology of Alcoholism in an Urban Residential Area," *Quart. J. Stud. Alcohol* 26:19-40, 1965.
12. Feighner, J., Robins, E., Guze, S. *et al.*: "Diagnostic Criteria for Use in Psychiatric Research," *Arch. Gen. Psychiat.*, 26:57-63, 1972.
13. Woodruff, R., Clayton, P., Cloninger, R. *et al*: "A Brief Method of Screening for Alcoholism," *Dis. Nerv. Syst.*, 37:434-435, 1976.



**remember today's USO**

USO World Headquarters
1146 19th Street, N.W.
Washington, D.C. 20036

*Support Your Advertisers*

**COOK COUNTY**
**Graduate School of Medicine**

CONTINUING EDUCATION COURSES
STARTING DATES—1978-1979

SPECIALTY REVIEW SURGERY, PART II, November 27
ADVANCES IN OB-GYN, 3 days, November 30
MANAGEMENT OF ACUTE CARDIAC PATIENT, 3 days, Nov. 29
SPECIALTY REVIEW UROLOGIC PATH. & X-RAY, December 4
SPECIALTY REVIEW THORACIC SURGERY, January 29
SPECIALTY REVIEW NEUROLOGICAL SURGERY, Feb. 2
CLINICAL MEDICINE, UPDATE, 5 days, February 19
NEUROLOGY, PART I, BASIC, February 26
BASIC REVIEW IN PSYCHIATRY, 5 days, March 12
SPECIALTY REVIEW SURGERY, PART II, March 12
ESSENTIALS OF ELECTROCARDIOGRAPHY, 5 days, March 19
ELECTROCARDIOGRAPHY FOR ANESTHESIOLOGISTS, March 19
CLINICAL & LABORATORY DIAGNOSIS OF HEMORRHAGIC AND THROMBOTIC DISORDERS, 2 days, March 23
DIAGNOSIS AND MANAGEMENT OF PROBLEMS IN GYNECOLOGY, March 26

*Information concerning numerous other continuation courses available upon request.*

**Address:**
**REGISTRAR, 707 South Wood Street, Chicago, Ill. 60612**

*Preliminary Report*

# A More Physiologic Skin Prep

By Hugh A. Johnson, M.D. and Larry D. Edwards, M.D./Rockford

*A series of 807 plastic surgical cases were operated using a surgical prep of physiologic solution only. In one case a lip incision became infected with the same organism cultured from a chalazion present at the time. In four cases there was drainage either from too tight sutures or following excision of ulcerating epitheliomas. This gave an over-all infection rate of 0.62%.*

Homeostasis (a tendency to stability in the normal body state of an organism) is a word seldom used today. It serves well to describe the symbiotic relationship we have with bacteria. In truth, we cannot live in health without our bacteria. The use of prophylactic antibiotics and their sometimes disastrous upsetting of homeostasis emphasizes this relationship. If we use strong chemicals in our surgical prep we must upset the homeostasis of our skin flora and leave the way open for the ill effects of an imbalance just as do "prophylactic antibiotics." It is essential to become aware of the reproductive needs of pathogenic organisms: their presence in significant numbers to propogate, a medium conducive to growth in large number, and a lowering of the host's defences.

The usual "thorough" surgical prep provides two of these three requirements, dead cells as the residue of strong chemicals, (soap, etc.) and traumatized tissue even the gentlest surgeon must leave behind. The hospital environment often provides the third—a significant number of pathogens to reproduce. All the requirements are fulfilled: natural skin resistence is destroyed by scrubbing and chemicals, the medium of dead cells is present and pathogens are introduced.

## An Example

A plastic and reconstructive surgeon who attempts to sterilize the face will occasionally get soap in a patient's eye. Such accidents illustrate what must be the disastrous effect on naked, exposed cells which are damaged even by air. Bacteriologists are aware that attempts to "sterilize" skin are ridiculous.

Logic suggested an attempt to perform facial surgery on out-patients (who don't come to the operating room drenched in nosocomial organisms) without a surgical prep. The face was gently wiped with a soft gauze sponge soaked in a physiologic solution (preferably Physiosol, Abbott Laboratories brand, a perfectly formulated irrigating solution but physiologic saline if unavailable) as a sop to the nurses' penchant for the antiquated antiseptic era. Admittedly, the experiment was approached with some trepidation. It is hard to overcome with reason the superstitions of a lifetime, and "malpractice" clouds one's thinking.

## Results

As the number of facial cases done without



HUGH A. JOHNSON, M.D., is in the private practice of plastic and reconstructive surgery in the Rockford Memorial Medical Building at the Rockford Memorial Hospital. He also maintains an office at Northwoods Hospital, Phelps, Wisconsin. Dr. Johnson is on the active staff at both Rockford Memorial Hospital and Northwoods Hospital, and is a consultant to the Sumner Koch Burn Unit at Cook County Hospital, Chicago, and the St. Anthony Burn Unit, Rockford.



LARRY D. EDWARDS, M.D., is an internist in Rockford. Doctor Edwards is director of the division of infectious diseases at the Rockford School of Medicine and a consultant for the Winnebago County Health Department. He is a diplomat of both the National Board of Medical Examiners and the American Board of Internal Medicine.

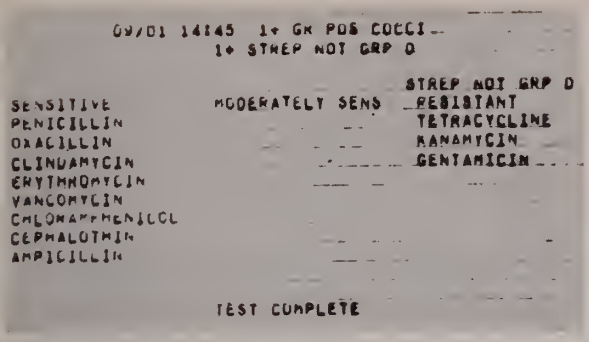



**Figure 1**
**Cultures of the infected case. The same organism for the stye and the infected wedge resection.**

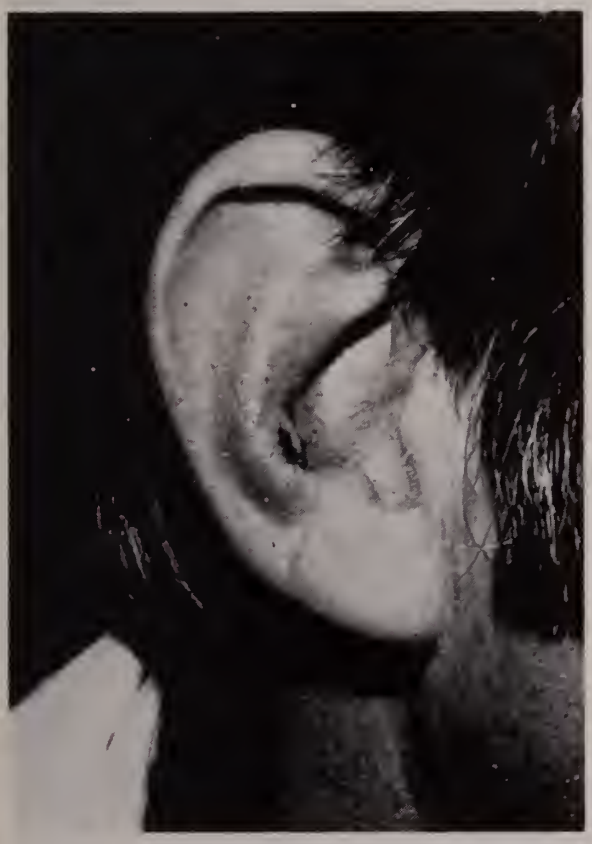


**Figure 3**
**Draining epithelioma**



**Figure 2**
**Sutures too tight—an alar base excision with slough and drainage.**



**Figure 4**
**Stent was too tight, produced slough at skin edges with drainage.**

infection increased, the method was attempted on theoretically more susceptible cases. It soon became obvious that logic applies to the rest of the body as well as the face. The prep has now been applied without infection to very susceptible cases. Even breast implants (the introduction of a foreign body, another factor) and abdominoplasty, dangerous because of the handling of a large amount of relatively avascular fat, have been completed successfully. A total of 807 operations using only a wipe with a physiologic solution on all areas of the body, including hands, can be reported. Only one true wound infection has resulted, a patient with a chalazion, on whom a wedge resection of an epithelioma of the lip became infected. The organism was the same from both lesions (Figure 1).

In three cases, faulty technique, too tight a wound closure, caused local slough, but not a true wound infection (Figures 2, 3, 4, 5 and 6).

One case, a longstanding recurrent and ulcerated epithelioma with bone exposed and con-



Figure 5
Healed without loss of graft



Figure 6
Too tight closure of wedge resection of ear with drainage.



Figure 7
Post-operative recurrent epithelioma with bone exposed.



Figure 8
Wound contaminated—but healed without loss of graft.

tamination before surgery remained contaminated throughout the healing phase, but healed without loss of skin graft (Figures 7 and 8). Counting all of these as infections gives a rate of 0.62%.

## Discussion

Several variables may have affected the present retrospective experiment. Every attempt was made to be a gentle surgeon. Tissue was viewed in terms of the surgeon's own eye—would you want someone to pick up your unanaesthetized conjunctiva with a large toothed forceps, or crushed by a haemostat, however small? Patients were admitted on the morning of surgery, which was performed in the afternoon and as many as possible were dismissed the next morning. As many as possible were out-patients which eliminated the nosocomial element.

A controlled series with quantitative bacterial cultures should be initiated to ascertain the effect of germicide versus physiologic preparation of the skin.

This can be accomplished by using two sites in the same patient (*e.g.* bilateral procedures on both ears, both breasts). One site could be prepared with a standard surgical scrub and the other site with physiologic saline. Quantitative bacterial cultures would be done before and after the prep and before closing the surgical wound. This study should be done on patients who are likely to have normal skin flora, *i.e.* not patients that have been exposed to the hospital's abnormal bacterial flora for a protracted period before surgery. Elective plastic surgery patients should be ideal.

Suture material could be considered foreign bodies as far as tissue reponse goes. A comparable series of cases using soap or other chemical surgical prep should be done. This would eliminate the variable of gentle surgeon vs. rough surgeon.

To meet this need, a local veterinary surgeon (also interested in the ideal prep) plans to supervise an experiment on cats brought to him for disposal. This will be single blind: the surgeon and veterinarian will do the prep but the bacteriologist alone will know into which surgical wound a significant number of pathogenic bacteria have been introduced. These findings should be contributory in resolving our questions about a physiologic skin prep for surgery. ◄


Statement of Ownership, Management and Circulation
(Required by 39 U.S.C. 3685)

1. Title of publication: IMJ—Illinois Medical Journal.
   A. Publication No. 258160.
2. Date of Filing: October 2, 1978.
3. Frequency of issue: Monthly.
   A. No. of issues published annually: 12.
   B. Annual subscription price: $8.00.
4. Location of known office of publication: 55 E. Monroe, Suite 3510, Chicago, Illinois 60603.
5. Location of the headquarters or general business offices of the publishers (not printers): 55 E. Monroe, Suite 3510, Chicago, Illinois 60603.
6. Names and complete addresses of publisher, editor and managing editor: Publisher: Illinois State Medical Society, 55 E. Monroe, Suite 3510, Chicago, Illinois 60603. Editor: Vacant. Managing editor: Richard A. Ott, 55 E. Monroe, Suite 3510, Chicago, Illinois 60603.
7. Owner (If owned by a corporation, its name and address must be stated and also immediately thereunder the names and addresses of stockholders owning or holding 1 percent or more of total amount of stock. If not owned by a corporation, the names and addresses of the individual owners must be given. If owned by a partnership or other unincorporated firm, its name and address, as well as that of each individual must be given.) Illinois State Medical Society, 55 E. Monroe, Suite 3510, Chicago, Illinois 60603.
8. Known bondholders, mortgagees, and other security holders owning or holding 1 percent or more of total amount of bonds, mortgages or other securities (If there are none, so state): None.
9. For Completion by Nonprofit Organizations Authorized to Mail at Special Rates (Section 132.122,PSM) The purpose, function, and nonprofit status of this organization and the exempt status for Federal income tax purposes have not changed during the preceding 12 months.
10. Extent and Nature of circulation.

| | Average no. copies each issue during preceding 12 months | Actual no. of copies of single issue published nearest to filing date |
|---|---|---|
| A. Total No. copies printed (net press run) | 15,446 | 15,400 |
| B. Paid Circulation | | |
| 1. Sales through dealers and carriers, street vendors and counter sales | 230 | 220 |
| 2. Mail subscriptions | 14,298 | 14,105 |
| C. Total paid circulation (sum of 10B1 and 10B2) | 14,528 | 14,325 |
| D. Free distribution by mail, carrier or other means samples, complimentary, and other free copies | 722 | 865 |
| E. Total distribution (sum of C and D) | 15,250 | 15,190 |
| F. Copies not distributed | | |
| 1. Office use, left over, unaccounted, spoiled after printing | 196 | 210 |
| 2. Returns from news agents | None | None |
| G. Total (Sum of E, F1 and 2—should equal net press run shown in A) | 15,446 | 15,400 |

11. I certify that the statements made by me above are correct and complete. (Signature and title of editor, publisher, business manager, or owner)

Richard A. Ott, Managing Editor

*Case Report*

# *Sudden Paraplegia Caused By An Intraspinal Schwannoma*

By James B. Mansfield, M.D./Elgin

*Intraspinal schwannomas most often arise from the posterior roots and present with either subacute or chronic symptomatology. An unusual case of paraplegia caused by hemorrhage within a schwannoma located anterior to the thoracic spinal cord is presented herein. To the author's knowledge, this is the first case reported in the literature.*

A 75-year-old white man was admitted to the hospital because of upper abdominal and low chest pain. It had been present for two to three weeks, was intermittent, and seemed to either radiate from the back anteriorly or vice versa. He had noted some constipation, but denied any urinary difficulties. Somewhat over four years previously an adenocarcinoma of the right colon was treated with a radical hemicolectomy. His postoperative course had been satisfactory and he had a weight increase of 25 lbs. He was known to have a positive serology which had been treated twice in the distant past with unknown medications. There was a rather vague history of somewhat progressive but intermittent weakness of the right leg for some five years.

While undergoing work-up of his pain, a spinal tap was performed. Analysis yielded a white cell count of 14, 80% of these segmented neutrophils and 20% lymphocytes, a total protein of 440 mg.% with a gamma globulin of 11%, and a VDRL positive to 2 dilutions. No measurement of spinal fluid dynamics was made. His only other significant laboratory abnormality was a serum RPR positive to 64 dilutions.



**Figure 1**
**Pantopaque myelogram with patient in head down position shows complete block at the lower level of T12.**



JAMES B. MANSFIELD, M.D., is o boord certified neurosurgeon who is on ottending physicion ot Shermon ond St. Joseph Hospitols in Elgin. Doctor Monsfield is olso o clinicol associote ot the UI Abroham Lincoln School of Medicine in Chicogo.



**Figure 2**
**Compactly arranged spindle cells with long oval nuclei are evident. Vascular congestion and hemorrhagic features are also seen. (H & E times 100)**

Two days later he was in the X-ray department having a barium enema performed when he suddenly lost strength and sensation in his legs. At this time, neurosurgical consultation was obtained. Abnormalities were limited to the lower extremities. Except for a bit of right hip extension, he was totally paraplegic. Deep tendon reflexes were absent in the legs without plantar response. There was no position and vibratory sensation in the lower extremities, and a sensory level to pinprick was present at about T11-12. Dexamethasone was begun.

Plain films of the thoracic spine showed no evidence of paraspinal mass or erosion of the bony structures. Spinal tap at the L4 interspace revealed blood tinged fluid with no increase in pressure in response to bilateral jugular venous compression or Valsalva maneuver. One cc. of pantopaque was injected and complete block was noted at the T12 level (Fig. 1).

An emergency thoracolumbar laminectomy was performed. No evidence of bony erosion or epidural tumor was found; however, palpation of the dural sac revealed an abnormally firm segment approximately 3 cm. in length. After opening the dura, the spinal cord appeared to be somewhat thinned out. No intramedullary tumor was visible, but slight retraction of the cord revealed a reddish-black ventral mass. This was attached to an anterior nerve root which was clipped and the 4x2x1.5 cm. nodular tumor was removed. Microscopic examination revealed this to be a schwannoma with vascular congestion and hemorrhagic features (Fig. 2).

The patient had no return of motor function in his legs postoperatively. Position sense returned to a moderately diminished state and the vibratory sensation to a markedly diminished one. He could differentiate sharp from dull in his legs, but a sensory level was still obtainable at about the L1 level. Steroids were gradually discontinued and he was discharged to a rehabilitation facility.

## Discussion

According to Russell and Rubinstein, intraspinal schwannomas arise almost invariably from the posterior roots.[1,3] Occasional involvement of motor roots has been recorded in the European, as opposed to English, literature; however, no case that presented with the precipitous onset of paraplegia has previously been noted.[2]

Selective involvement of the posterior roots accounts for the high incidence of radicular pain as a first symptom of the tumor. This patient's vague history of right leg weakness may have been indicative of pressure on the ventral cord from the slowly growing tumor. Hemorrhage within the tumor with consequent sudden enlargement of the mass and pressure upon the already compromised spinal cord is postulated as causing the sudden onset of paraplegia. Limited recovery of function was confined to the posterior columns, which was the area of spinal cord most distant from the insult. This case is presented because of its rarity and because it occurred in a setting thought preoperatively to be most compatible with metastatic tumor to the spine.

## References


1. Gautier-Smith, T. C.: *Brain* 90: 359, 1967.
2. Henschen, F.: (1910) Ueber Geschwulste der Hinteren Schadelgrube insbesondere des Kleinhirnbruckenwinkels, Fischer, Jena; (1955) In *Handbuch der speziellen pathologischen Anatomie und Histologie,* Lubarsch, O., Henke, F., and Rossle, R., Springer-Verlag, Berlin, Vol. 13 pt. 3, p. 938.
3. Russell, D. S., Rubinstein, L. J.: PATHOLOGY OF TUMOURS OF THE NERVOUS SYSTEM, 3rd ed., Baltimore, Williams & Wilkins Company, 1971.

# Factitial Panniculitis

By Valee Harisdangkul, M.D., Ph.D., Michael H. Ellman, M.D.,
Bruce Bennin, M.D., David E. Fretzin, M.D./Chicago

*Panniculitis mimicking Weber-Christian Disease, induced by self inoculation of pentazocine, was seen in a 50-year old patient. The factitial nature of the skin nodules was proven by the presence of multiple, small birefringent particles seen under partially polarized light microscopy of the biopsy specimens.*

Factitial panniculitis induced by self injection of pentazocine*[1] and meperidine hydrochloride†[2] may closely simulate Weber-Christian disease.[3] When panniculitis is induced by self injection of drugs, birefringent foreign material may be seen by polarized microscopy in biopsy specimens of involved skin.[2] We wish to report a case of factitial panniculitis induced by pentazocine administration, initially diagnosed as Weber-Christian disease, in order to remind physicians of this unusual but perhaps not so rare entity.[1,2]



VALEE HARISDANGKUL, M.D., Ph.D., is a resident in internal medicine affilated with the University of Misisssippi Medical Center in Jackson, Mississippi. A farmer fellow in rheumatology at both Michael Reese Medical Center in Chicago and the New York Hospital for Special Surgery, Doctor Harisdangkul is particularly concerned with teaching and research in clinical rheumatology, immunology and pathogenic mechanisms of systemic lupus erythematosus.

MICHAEL H. ELLMAN, M.D., is the director of the Michael Reese Hospital division of rheumatology. Doctor Ellman is vice president of the Chicago Rheumatism Society and chairman of the Illinois Chapter, Arthritis Foundation medical and scientific committee. He is also an assistant professor affiliated with the University of Chicago Pritzker School of Medicine.

BRUCE BENNIN, M.D., is a board-certified dermatologist affiliated with Highland Park Hospital and Cook County Hospital in Chicago. Dactor Bennin is a fellaw of the American Academy of Dermatology.

DAVID E. FRETZIN, M.D., is a clinical assaciate professor in the University of Chicago divisian af dermatology and director of the Michael Reese Haspital department of medicine divisian af dermatalogy. Doctor Fretzin is also an attending physician in the departments of medicine and pathology at Michael Reese, and attending staff for Lutheran General Hospital in Park Ridge. He is baard certified by the American Boards af Dermatology and Dermatopathology.

*Talwin
†Demerol
§Sparine

## Case Report

A 50-year old black woman was seen at the Arthritis Clinic of Michael Reese Medical Center with the chief complaint of chronic, painful skin nodules of the thighs and buttocks. Painful, discrete nodular skin lesions of the thighs associated with fever first appeared in 1972 and spontaneously resolved within one year. The lesions reappeared in 1974 as multiple, red, hot and painful nodules again involving her thighs and buttocks draining whitish foamy material. Weber-Christian disease was diagnosed at another hospital after clinical evaluation and surgical biopsy. The patient was purportedly instructed to inject pentazocine and promazine§ intramuscularly into her buttocks for relief of pain. Past history revealed no major illnesses except for severe migraine headaches that required hospitalization and use of parenteral analgesics.

On physical examination she had multiple indurated, erythematous solitary to coalescing skin and subcutaneous nodules ranging in size from 2 cm to more than 10 cm in diameter. They involved both prox-

imal thigh areas. (Figure 1) buttocks and the right side of the anterior abdominal wall. Several nodules were also found on the posterior aspect of the right calf. A few nodules on either side of her thighs were draining purulent material. Older healed lesions appeared fibrotic and atrophic.

Hospital evaluation was entirely normal except for eosinophilia on three occasions ranging from 5 to 12%, urinalyses with trace proteinuria and an erythrocyte sedimentation rate (Westergren) of 58 mm/hr. A lipid profile by agarose gel electrophoresis showed Type II-A hyperlipoproteinemia; amylase, lipase and $\alpha$-1-antitrypsin values were within normal limits. The antinuclear antibody test and complement levels were negative or normal. Chest and femur roentgenograms were normal.

Multiple surgical biopsies of new and healed subcutaneous nodules were obtained. Cultures and stains for acid-fast bacilli and fungi were negative. Histopathologic examination of a new lesion revealed acute and chronic inflammation of the subcutaneous tissue with infiltration by polymorphonuclear leukocytes, eosinophils, lymphocytes, histiocytes, giant cells and foamy histiocytes as well as focal necrosis. Older lesions showed less inflammation and considerable fibrosis. Polarized microscopy revealed multiple, birefringent small crystal-like particles in both old and new lesions (Figure 2) supporting the diagnosis of factitial panniculitis.



**Figure 1**
**Photograph of both thighs showing multiple, indurated, erythematous skin nodules with a few ulcerated lesions.**

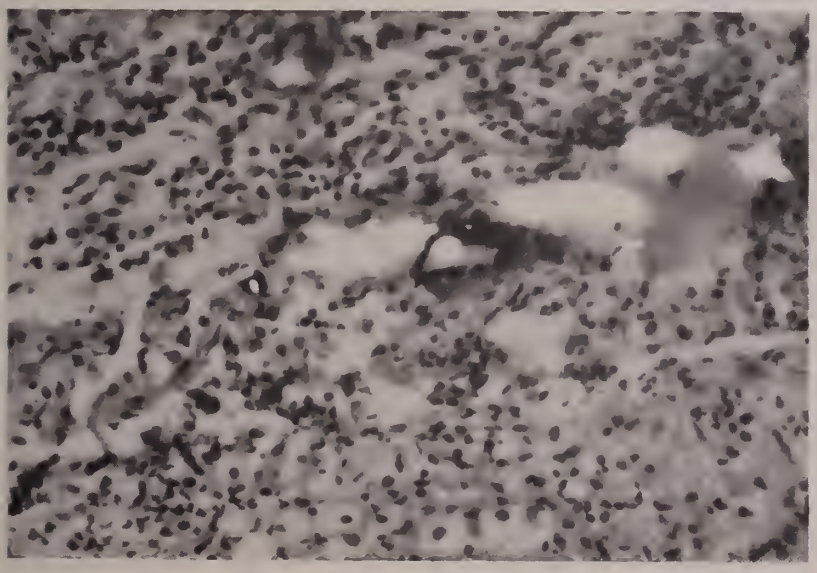


**Figure 2**
**Photomicrograph of skin biopsy showing multiple birefringent particles surrounded by inflammatory cells when examined under partially polarized microscopy. Original magnification X 120.**

The patient was informed of the histologic finding of foreign material in the skin biopsies. This prompted admission of self administration of pentazocine for migraine headaches prior to the onset of skin nodules with the subsequent development of addiction to this drug. She was relieved to know that she had no primary panniculitis and agreed to participate in a drug withdrawal program.

## Discussion

The general features of Weber-Christian disease are relapsing nodular non-suppurative panniculitis often associated with fever, leukocytosis and eosinophilia. It is a disease of unknown etiology with a female predominance. In the localized form involving only the panniculus adiposus, it is a rather benign disease and resolution usually occurs following months or years of active lesions. Cases associated with a variety of systemic manifestations have been described. In re-

viewing the literature, MacDonald and Feiwel proposed that Weber-Christian disease is not a distinct clinical entity and the term nodular panniculitis be used instead when the etiologic factor(s) is not known.[3] There is a more malignant form of systemic Weber-Christian disease involving visceral organs including pleura, lungs, bowels, kidneys and mesenteric adipose tissues.[4] More recently, the syndrome of subcutaneous fat necrosis, polyarthritis, polyserositis and pancreatic disease was described.[5-7] The relationship of this clinical entity to systemic Weber-Christian disease remains obscure. When visceral involvement of fat necrosis is extensive, the disease may be fatal.

Our patient presented clinically with extensive involvement of nonsuppurative subcutaneous panniculitis. Histopathologic examination of biopsy tissues by routine light microscopy did not help in the differential diagnosis of Weber-Christian disease versus factitial panniculitis. In our patient, crystalline material was seen in all biopsy specimens under polarized light microscopy leading to the diagnosis of factitial panniculitis. Förström and Winkelmann have emphasized the usefulness of polarized light microscopy in the differential diagnosis of Weber-Christian disease in their two cases and we agree with them that this technique should be routinely used. In our patient, the cessation of surreptitious intramuscular injections of pentazocine and promazine prompted remission.

**References**


1. Parks, D. L., Peny, H. O., and Muller, S. A.: "Cutaneous Complications of Pentazocine Injections," *Arch. Derm.* 104:231-235, 1971.
2. Förström, L. and Winkelmann, R. K.: "Factitial Panniculitis," *Arch. Derm.* 110:747-750, 1974.
3. MacDonald, A. and Feiwel, M.: "A Review of the Concept of Weber-Christian Panniculitis with a Report of Five Cases," *Brit. J. Derm.* 80:355-361, 1968.
4. Milner, R. D. G. and Mitchinson, M. J.: "Systemic Weber-Christian Disease," *J. Clin. Path.* 18:150-156, 1965.
5. Gibson, T. J., Schumacher, H. R., Pascual, E., and Brighton, C.: "Arthropathy, Skin and Bone Lesions in Pancreatic Disease," *J. Rheum.* 2:7-13, 1975.
6. Potts, D. E., Mass, M. F., and Iseman, M. D.: "Syndrome of Pancreatic Disease, Subcutaneous Fat Necrosis and Polyserositis," *Amer. J. Med.* 58:417-423, 1975.
7. Tannenbaum, H., Anderson, L. G., and Schar, P. H.: "Association of Polyarthritis, Subcutaneous Nodules, and Pancreatic Disease," *J. Rheum.* 2:14-20, 1975.



AVIS

**New ISMS Membership Service**

The Illinois State Medical Society has made a special Avis car rental discount program available to all members as of January, 1979.

In January, when ISMS membership cards are distributed, a special number will be printed on the face. This AID number identifies your eligibility for a special discount program.

This program incorporates some of the largest discounts obtainable and provides ISMS members with the most economical Avis car rental rates. For example, in the continental United States, you are eligible for a 15% discount on Avis' regular time and mileage rates. Internationally, to include Canada, a 10% discount is offered. Exceptions are very few: non-automated locations or special free unlimited mileage rates.

The key to obtaining these money-saving discounts is the Avis AID identification number. When you rent a car at any of the 3,300 Avis counters throughout the world, the AID number on your ISMS membership card can be used in conjunction with any Avis honored charge card or any qualified cash rental. The AID number becomes effective immediately upon receipt.

So associate with Avis, for special discounts wherever you drive.

"We Try Harder"

# surgical grand rounds

Edited By JOHN M. BEAL, M.D.

*Surgical Grand Rounds are held weekly on Tuesday at 5:00 p.m. in the Offield Auditorium of the Passavant Pavilion of Northwestern Memorial Hospital. Patient presentations from Northwestern Memorial Hospital and the Veterans Administration Lakeside Hospital form the basis of the discussions. This case report was part of the Surgical Grand Rounds of August 8, 1978.*

## Case Report

# Branchial Cleft Cyst

**Dr. David Katrana:** A 22-year-old Caucasian girl complained of a painless mass in her neck. She stated that the mass was noted approximately 10 years ago. During this period, she had noticed some fluctuation in size, but recently it had markedly increased. It had not been inflammed or painful, nor had it drained. She did not have a history of a significant dental or intraoral inflammatory process. She was in good general health.

Her past medical history was insignificant, excepting a severe episode of streptococcal infection with a toxic course at age 10 years. She had been hospitalized and rheumatic fever was diagnosed. A residual heart murmer was noted but she has not manifested any clinical sequelae. Her history included a tonsillectomy and wisdom teeth extraction.

On physical examination, positive findings were confined to the mass in her neck, which was three cm in diameter. It was soft, mobile beneath the skin, but apparently fixed to deep structures. It was painless and there was no intraoral manifestation of disease. No evidence was found of oropharyngeal infection or inflammation. There was a grade two over six systolic ejection murmur at the sternal border. Her preoperative laboratory studies including blood count, chest X-ray, and urinalysis were within normal limits.

She was given 600,000 units of aqueous penicillin and 600,000 units of procaine penicillin prior to operation and the neck was explored under endotracheal anesthesia. There was a small stalk associated with the mass, but it did not communicate with either pharynx or external auditory canal.

**Dr. Ryoichi Oyasu:** The specimen consisted of a cystic mass, 2.5 cm in diameter, bounded by fibroadipose tissue. The content of the cyst was cheesy brown material. Microscopically, the wall of the cyst varied in thickness, accompanied with varying amounts of lymphoid tissue, (Fig. 1) with or without germinal centers. The inner surface was lined by keratimizing stratified squamous epithelium. Outside the cyst wall, foreign body giant cell reaction was found in some areas, apparently as a reaction to the spilled content of the cyst. The typical branchial cleft cyst may be lined by either stratified squamous or stratified columnar epithelium or a combination of both types. In this particular case, however, the entire cyst was made up of squamous epithelium.

From the pathological point of view, differential diagnoses include an epidermoid cyst and a cystic metastasis of squamous cell carcinoma to lymph node. The former can be excluded be-

cause of lack of lymphoid tissue outside the cyst wall, and the latter may be ruled out because of lack of atypia in the epithelial component.

**Dr. David Katrana:** The patient had an uneventful postoperative recovery. She went home the day after operation and received penicillin for two days postoperatively. We felt that she required prophylactic antibiotics for several reasons: she had evidence of rheumatic heart disease and antibiotic therapy reduced the risk of damage to her heart from bacteremia of the surgery or of the endotracheal tube. If we needed to go into her mouth and trace the tract of this cyst, penicillin would afford additional protection to the wound.

### Pertinent Background Information

The branchial arches begin to develop about the fourth fetal week, and tissue rests trapped during this time have been associated with residual cysts in the area. The embryology is important is predicting the location of cyst tracts. For instance, the first branchial arch is responsible for producing the maxillary and mandibular processes. Its associated internal pouch and external groove contribute to the development of the eustacian tube and external auditory canal. The second arch is responsible for a portion of the upper neck skin and its pouch produces the tonsillar fossa.

In the process of obliteration of the grooves and pouches in development of these structures, it is felt that cellular rests are left within the tissue. These can later manifest themselves either as a cyst, sinus, or fistula, depending on the anatomy that is present. A sinus is defined as an opening onto either skin or mucosa surface and a fistula as a penetrating defect.

The branchial cleft cysts are associated with second branchial groove pouch and arch in 95% of occurrences. The remnant of the second branchial pouch is the tonsillar fossa and a tract that persists in the course of the migration of the arch downward on to the neck follows the arch in its development. For this reason, the lesion in a second branchial cleft anomaly most commonly manifests in the area of the carotid triangle, and a tract, if present, extends toward the tonsillar fossa. The tract will frequently go between internal and external carotid adjacent to glosso pharyngeal and hypoglossal nerves, deep to the posterior belly of the digastric. In this event, it will exit in the posterior aspect of the tonsillar fossa, and sometimes through the tonsil itself, if it is present.

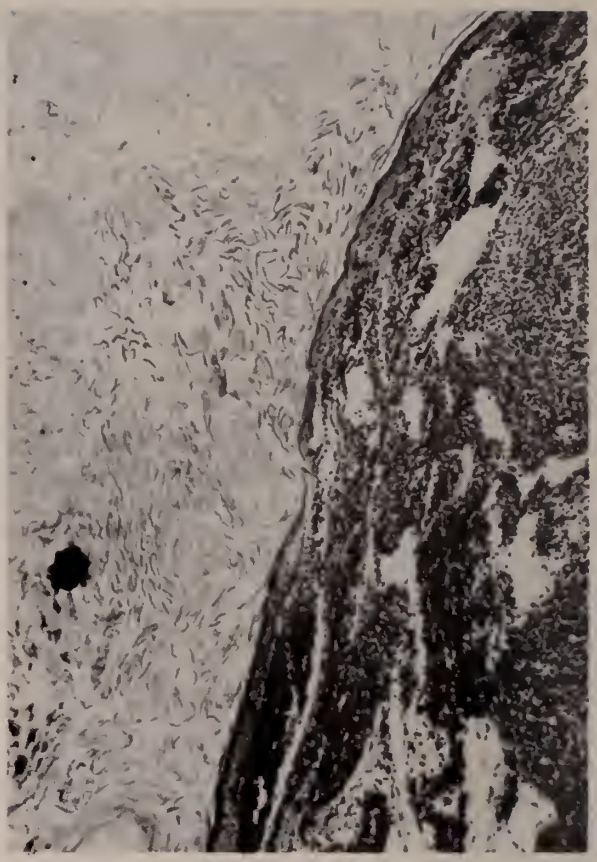


**Figure 1**
**Wall of cyst contains lymphoid tissue and is lined with stratified squamous epithelium.**

Anomalies of the first arch are usually located along the horizontal part of the mandible and tract past the carotid in close junction with the trunk of the cranial nerve, and up into the area of the external auditory canal. In fact, a draining external fistula and a draining ear canal are pathognomonic of this fistula, assuming primary ear disease is ruled out.

### Thyroglossal Duct Cysts

A discussion of congenital neck cysts should also include those associated with the thyroglossal duct. The foramen cecum at the base of the tongue is the origin of the thyroglossal duct which migrates down in the neck through the hyoid bone, and ends in the midneck at the thyroid gland. Development begins about the same time embryologically as the first and second branchial arches, and the anomaly most commonly manifests as a midline neck mass. Motion with swallowing is characteristic. As the hyoid

bone moves with the pharynx on swallowing, the tract through it puts tension on the cyst. A thyroid scan is frequently indicated in these patients to prove the presence of functioning thyroid tissue and that indeed the mass is not the only thyroid tissue present.

The recurrence rate of thyroglossal duct cysts has been reported as high as 20% and is usually essentially considered an incomplete resection. It is mandatory to excise the central portion of the hyoid bone and follow the tract even to the base of the tongue if necessary.

A brief differential diagnosis of neck lesions would seem indicated. An isolated neck mass in a child is most commonly inflammatory in origin and the second most common mass is associated with lymphomas. In an adult, a neck mass is considered carcinoma until proven otherwise as 85% have been found to be metastatic and the remaining 15% primary. Of the metastatic, again, 85% are associated with the head and neck and the other 15% are from lesions located below the clavicle. Surgical excision of congenital cysts in the neck must not be taken lightly. They require endotracheal anesthesia and preparations to follow the tract to its internal origin if necessary. Multiple vital structures are associated with the dissection and require total surgical and anesthetic control as described.

**Dr. Peter McKinney:** The essential points are that because the first and second arches grow in a caudal direction they can cover over the folds and the grooves. If these are not completely obliterated, a cyst of this nature can develop. If it is lateral, you have to be prepared to dissect to the tonsillar bed or to the ear. If it is midline, you must be prepared to go to the base of the tongue. The treatment is entirely surgical. Some of the literature discusses incisions, aspirations or sclerosing solutions, but these are useless. The horizontal incisions are to be preferred in the neck, of course, and subcuticular sutures avoid suture marks. With a fistula, there may be drainage on the outer aspect of the neck and in our experience this has indicated a tract to the pharaynx. With an isolated cyst, this is unlikely but must be considered. The recurrence rate should be quite low; malignancy is possible but not common. In very rare instances, these masses represent functioning thyroid tissue. ◄

★
*Specialized Service*
IN
PROFESSIONAL LIABILITY INSURANCE
*is a high mark of distinction*
Since 1899
THE
MEDICAL PROTECTIVE COMPANY
FORT WAYNE, INDIANA

CHICAGO AREA OFFICE:
T. J. Pandak, J. C. Kunches, L. R. Gannon, and W. G. Prangle, Representatives
814 Commerce Drive, Suite 109, Oak Brook, Illinois 60521 (312) 325-7314
SPRINGFIELD OFFICE: W. J. Nattermann, Representative
426½ South Fifth Street, Springfield 62701 (217) 544-2251

# ISMS Guide to Continuing Medical Education

Compiled for Illinois physicians by the
ILLINOIS COUNCIL ON CONTINUING MEDICAL EDUCATION
55 E. Monroe St., Suite 3510 • Chicago, IL 60603 • (312) 236-6110

*Items for this Calendar must be received 90 days prior to the event. Those received earlier may appear in up to three monthly issues.*

*WARNING! Items for this Calendar come from many sources, often far in advance of the publication date. Sometimes, cancellations or changes in date, place or time occur too late to be corrected before publication. You are urged to contact the sponsoring organization to confirm information given below.*

## DECEMBER

### *Colposcopy*

**COLPOSCOPY**
**For:** MD's. Conference, Dec. 8-9, Chicago. **Sponsor:** Northwestern University Medical School, Alumni Center for Continuing Education, 301 E. Chicago Ave., Chicago 60611. **Fee:** $150. **CME Credit:** AMA Category 1, 12 hours. **Contact:** James Dyson, Ph.D. **Phone:** 312-649-8533.

### *Family Medicine*

**UPDATE—PRIMARY CARE MEDICINE**
**For:** GP's, FP's, Internists. Lectures, Dec. 12 & 15, 8:00 a.m., Chicago. **Sponsor:** Grant Hospital, 550 W. Webster, Chicago 60614. **Fee:** none. **Reg. limit:** none. **CME Credit:** AMA Category 1, 2 hours. **Contact:** P. Colon. **Phone:** 312-883-2112.

### *Family Therapy*

**TECHNIQUES FOR WORKING WITH SEVERELY DISTURBED FAMILIES**
**For:** MD's. Workshop, Dec. 1, 9:30-4:30 p.m., Chicago. **Speaker:** Froma Walsh, Ph.D. **Sponsor:** Center for Family Studies/The Family Institute of Chicago, 10 E. Huron St., Chicago 60611. **Cosponsors:** Institute of Psychiatry, Northwestern Memorial Hospital, Northwestern University Medical School. **CME Credit:** AMA Category 1, 6 hours. **Contact:** Wendy Brockington. **Phone:** 312-649-7285.

### *Internal Medicine*

**JAUNDICE**
**For:** MD's, office staff. Symposium, Dec. 7, 1:00-5:00 p.m., DuQuoin. **Sponsor:** SIU School of Medicine, 801 No. Rutledge, P.O. Box 3926, Springfield, IL. **Fee:** $25 pre. **Reg. limit:** none. **CME Credit:** AMA Category 1, 4 hours. **Contact:** Lorraine Stephenson. **Phone:** 217-782-7711.

### *Medicine*

**MEDICAL ASPECTS OF ALCOHOLISM**
**For:** MD's, students, general public. Seminar, Dec. 1, 1:00-4:00 p.m., Palmer House, Chicago. **Sponsor:** Illinois State Medical Society. **Credit:** AMA Category 2, 3 hours. **Fee:** none. **Reg. limit:** none. **Contact:** Debbie Frei-Lahr, 5553 So. Ingleside, Chicago, IL 60637. **Phone:** 312-955-6267.

### *Obstetrics/Gynecology*

**OBSTETRICS & OFFICE GYNECOLOGY**
**For:** MD's, office staff. Symposium, Dec. 7, 5:00-9:00 p.m., Lawrenceville. **Sponsor:** SIU School of Medicine, 801 No. Rutledge, P.O. Box 3926, Springfield, IL 62708. **Fee:** $25 pre. **Reg. limit:** none. **CME Credit:** AMA Category 1, 4 hours. **Contact:** Lorraine Stephenson. **Phone:** 217-782-7711.

### *Psychiatry*

**INTRODUCTION TO THE ART OF SELF-CARE & CONFLICT MANAGEMENT**
**For:** Psychiatrists, MD's. Lecture, Dec. 20, 1:00-4:00 p.m., Forest Park. **Speaker:** Yetta Bernhard, MS. **Sponsor:** Riveredge Hospital Foundation, 8311 W. Roosevelt Road, Forest Park, IL 60130. **Fee:** $15. **CME Credit:** AMA Category 1, 3 hours. **Contact:** Susan Cosgrove. **Phone:** 312-771-7000.

### *Psychiatry*

**OFFICE PSYCHIATRY**
**For:** MD's, office staff. Symposium, Dec. 14, 7:00-10:00 p.m., Effingham. **Sponsor:** SIU School of Medicine, 801 No. Rutledge, P.O. Box 3926, Springfield, IL 62708. **Fee:** $25 pre. **Reg. limit:** none. **CME Credit:** AMA Category 1, 3 hours. **Contact:** Lorraine Stephenson. **Phone:** 217-782-7711.

### *Urology*

**SPECIALTY REVIEW IN UROLOGIC PATHOLOGY**
**For:** Urologists. 4-day lecture, Dec. 4, Chicago. **Speakers:** Thomas John, MD.; Irving Bush, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 South Wood St., Chicago, IL 60612. **Fee:** $200. **Reg. limit:** 100. **Credit:** AMA Category 1, 32 hours. **Contact:** Robert Baker, MD. **Phone:** 312-733-2800.

## JANUARY

### *Family Medicine*

**ETHICAL ISSUES IN CRITICAL CARE**
**For:** GP's. Lecture, Jan. 10, 2:00-5:00 p.m., Chicago. **Sponsor:** The University of Chicago Medical Center, Frontiers of Medicine, 950 E. 59th St., Box 451, Chicago 60637. **Fee:** $20. **Reg. limit:** none. **CME Credit:** AMA Category 1, 3 hours; AAFP Elective, 3 hours. **Contact:** Elaine Ehrman. **Phone:** 312-947-5777.

### *Family Medicine*

**UPDATE—PRIMARY CARE MEDICINE**
**For:** GP's, FP's, Internists. Lectures, Jan. 5 & 26, 8:00 a.m., Chicago. **Sponsor:** Grant Hospital, 550 W. Webster, Chicago 60614. **Fee:** none. **Reg. limit:** none. **CME Credit:** AMA Category 1, 2 hours. **Contact:** P. Colon. **Phone:** 312-883-2112.

### *Family Medicine*

**9TH ANNUAL WINTER REFRESHER COURSE FOR FAMILY PHYSICIANS**
**For:** FP's. 3-day course, Jan. 17-19, Pfister Hotel, Milwaukee, Wisc. **Sponsor:** Department of Family Practice, The Medical College of Wisconsin, 610 North 19th St., Milwaukee, Wisc. 53233. **Cosponsor:** SE Chapter, Wisconsin Academy of Family Physicians. **Reg. deadline:** 1/5. **Fee:** $160. **Reg. limit:** 225. **Credit:** AAFP Prescribed, 21 hours; AMA Category 1, 21 hours. **Contact:** Susanna Rechlitz. **Phone:** 414-933-0700.

### *Internal Medicine*

**RHEUMATIC DISEASES: CURRENT CONCEPTS OF PATHOGENESIS, DIAGNOSIS AND MANAGEMENT**
**For:** Rheumatologists, Internists, FP's. Lecture, Jan. 18, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School, Towsley Center for CME, Ann Arbor, Michigan 48109. **Fee:** $130. **Reg. limit:** 400. **Credit:** AAFP Prescribed, 18 hours; AMA Category 1, 18 hours. **Contact:** Floyd Pennington. **Phone:** 313-764-2287.

### *Medical/Legal*

**24TH MEDICAL/LEGAL SEMINAR FOR LAKE COUNTY**
**For:** MD's. Seminar, Jan. 24, 8:00 a.m., Waukegan. **Sponsor:** St. Therese Hospital, 2615 Washington, Waukegan, IL 60085. **Fee:** $2.50. **Credit:** AMA Category 1, 5 hours. **Contact:** R. M. Adelman, MD. **Phone:** 312-688-6461.

### *Medicine*

**14th ANNUAL MEETING**
**For:** FP's. Symposium/workshop, Jan. 14-19, Las Vegas, Nevada. **Speaker:** Michael De Bakey, MD. **Fee:** $250. **Reg. limit:** none. **CME Credit:** AMA Category 1, 40 hours. **Sponsor:** American Society of Contemporary Medicine and Surgery, 6 No. Michigan Ave., Chicago 60602. **Contact:** John Bellows, MD. **Phone:** 312-236-4673.

### *Family Therapy*

**PERSONAL/PROFESSIONAL GROWTH WORKSHOP FOR THERAPISTS: WITH OR WITHOUT PARTNERS**
**For:** MD's, therapists. Seminar, Jan. 25, 26, 27, Oak Park. **Speaker:** Charles Kramer, MD. **Sponsor:** Center for Family Studies/The Family Institute of Chicago, 10 E. Huron, Chicago 60611. **Cosponsors:** Institute of Psychiatry, Northwestern Memorial Hospital, Northwestern University Medical School. **Reg. limit:** 16. **CME Credit:** AMA Category 1, 17 hours. **Contact:** Wendy Brockington. **Phone:** 312-649-7285.

### *Family Therapy*

**LAW IN THE EVERYDAY PRACTICE OF PSYCHOTHERAPY**
**For:** MD's. Workshop, Jan. 26 & 27, 9:30-4:30 p.m., Chicago. **Speaker:** Sandra Nye, JD, MSW. **Sponsor:** Center for Family Studies/The Family Institute of Chicago, 10 E. Huron, Chicago 60611. **Cosponsors:** Institute of Psychiatry, Northwestern Memorial Hospital, Northwestern University Medical School. **Reg. limit:** 40. **CME Credit:** AMA Category 1, 12 hours. **Contact:** Wendy Brockington. **Phone:** 312-649-7285.

### *Ophthalmology*

**14th ANNUAL SCIENTIFIC ASSEMBLY**
**For:** Ophthalmologists. Seminars/lectures/workshops, Jan. 14-19, Las Vegas, Nevada. **Sponsor:** American Society of Contemporary Ophthalmology, 6 No. Michigan Ave., Chicago 60602. **Fee:** $250. **Reg. limit:** none. **CME Credit:** AMA Category 1, 40 hours. **Contact:** John Bellows, MD. **Phone:** 312-236-4673.

### *Ophthalmology*

**THE ROLE OF THE PRIMARY PHYSICIAN IN EYE CARE**
**For:** FP's, Internists, Pediatricians. Workshop, 3 sessions in 1979, Chicago. **Sponsor:** Dept. of Ophthalmology, University of Illinois, 1855 W. Taylor, Chicago 60612. **Fee:** $200/session. **Reg. limit:** 40. **CME Credit:** AMA Category 1. **Contact:** Carmen Carrasco. **Phone:** 312-996-8023.

### *Psychiatry/Psychology*

**NARCISSISTIC FACTORS IN PSYCHOTHERAPY**
**For:** MD's, Psychiatrists. Lecture, Jan. 17, 1:00-4:00 p.m., Forest Park. **Speaker:** Arnold Goldberg, MD. **Sponsor:** Riveredge Hospital Foundation, 8311 W. Roosevelt Rd., Forest Park 60130. **Fee:** $15. **CME Credit:** AMA Category 1, 3 hours. **Contact:** Susan Cosgrove. **Phone:** 312-771-7000.

## FEBRUARY

### *Anesthesiology*

**REGIONAL ANESTHESIA**
**For:** Anesthesiologists. 5-day lecture, Feb. 26, Chicago. **Speaker:** Vincent Collins, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 South Wood St., Chicago, IL 60612. **Fee:** $325. **Reg. limit:** 10. **Credit:** AMA Category 1, 40 hours. **Contact:** Robert Baker, MD. **Phone:** 312-733-2800.

### *Ear, Nose and Throat*

**COMMON EAR, NOSE AND THROAT PROBLEMS**
**For:** GP's. Lecture, Feb. 14, 1:30-4:45 p.m., Chicago. **Sponsor:** The University of Chicago Medical Center, Frontiers of Medicine, 950 E. 59th St., Box 451, Chicago, IL 60637. **Fee:** $20. **Reg. limit:** none. **Credit:** AAFP Elective, 3 hours; AMA Category 1, 3 hours. **Contact:** Mrs. Elaine Ehrman. **Phone:** 312-947-5777.

*Emergency Care*

**EMERGENCY MEDICINE**
**For:** FP's, Emergency MD's. Lecture/workshop, Feb. 19-23, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School, Towsley Center for CME, Ann Arbor, Michigan 48109. **Cosponsor:** American College of Emergency Physicians, Michigan Affiliate. **Fee:** $275. **Reg. limit:** 500. **Credit:** AAFP Prescribed, 35 hours; AMA Category 1, 35 hours. **Contact:** Floyd Pennington. **Phone:** 313-764-2287.

*Family Medicine*

**UPDATE—PRIMARY CARE MEDICINE**
**For:** GP's, FP's, Internists. Lectures, Feb. 2, 16, 23, 8:00 a.m., Chicago. **Sponsor:** Grant Hospital, 550 W. Webster, Chicago, IL 60614. **Fee:** none. **Reg. limit:** none. **Credit:** AMA Category 1, 3 hours. **Contact:** Ms. P. Colon. **Phone:** 312-883-2112.

*Family Medicine*

**CLINICAL MEDICINE UPDATE**
**For:** GP's, FP's. 5-day lecture, Feb. 19, Chicago. **Speaker:** Sheldon Waldstein, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 South Wood St., Chicago, IL 60612. **Fee:** $225. **Reg. limit:** 100. **Credit:** AMA Category 1, 40 hours. **Contact:** Robert Baker, MD. **Phone:** 312-733-2800.

*Family Therapy*

**THE THERAPIST'S OWN FAMILY**
**For:** Therapists. Lecture series, Feb.-June, 9:00-1:00 p.m., Oak Park. **Speaker:** Jeannette Kramer. **Sponsor:** Center for Family Studies/Family Institute of Chicago, 10 E. Huron, Chicago, IL 60611. **Cosponsor:** Institute of Psychiatry, Northwestern Memorial Hospital, Northwestern University Medical School. **Fee:** $150. **Reg. limit:** none. **Credit:** AMA Category 1, 20 hours. **Contact:** Wendy Brockington. **Phone:** 312-649-7285.

*Family Therapy*

**FAMILY SYSTEMS ASSESSMENT—INTRODUCTORY COURSE**
**For:** Therapists. Course, Feb. 5-9, Chicago. **Sponsor:** Center for Family Studies/Family Institute of Chicago, 10 E. Huron, Chicago, IL 60611. **Cosponsor:** Institute of Psychiatry, Northwestern Memorial Hospital, Northwestern University Medical School. **Fee:** $155. **Credit:** AMA Category 1, 27.5 hours. **Contact:** Wendy Brockington. **Phone:** 312-649-7285.

*Family Therapy*

**INTEGRATION OF CULTURAL HISTORY INTO ASSESSMENT AND INTERVENTION**
**For:** Therapists. 3-day conference, Feb. 22-24, Chicago. **Speakers:** George Vassiliou, MD., Vasso Vassiliou, PhD. **Sponsor:** Center for Family Studies/Family Institute of Chicago, 10 E. Huron St., Chicago, IL 60611. **Cosponsors:** Institute of Psychiatry, Northwestern Memorial Hospital, Northwestern University Medical School. **Fee:** $120. **Credit:** AMA Category 1, 18 hours. **Contact:** Wendy Brockington. **Phone:** 312-649-7285.

*Family Therapy*

**STRATEGIES AND TECHNIQUES—INTERMEDIATE COURSE**
**For:** Therapists. Course, Feb. 12-16, Chicago. **Sponsor:** Center for Family Studies/Family Institute of Chicago, 10 E. Huron, Chicago, IL 60611. **Cosponsor:** Institute of Psychiatry, Northwestern Memorial Hospital, Northwestern University Medical School. **Credit:** AMA Category 1, 27.5 hours. **Contact:** Wendy Brockington. **Phone:** 312-649-7285.

*Forensic Medicine*

**REVIEW OF CURRENT FORENSIC PATHOLOGY CASES**
**For:** MD's, DDS's, LIB's. Lecture/workshop, Thursdays, 2:00 p.m., Chicago. **Sponsor:** Office of the Medical Examiner, Cook County, IL, 1828 West Polk St., Chicago, IL 60612. **Fee:** none. **Reg. limit:** 50. **Contact:** Robert Stein, MD. **Phone:** 312-443-5017.

*Internal Medicine*

**USE OF THE LABORATORY IN CLINICAL PRACTICE**
**For:** Internists, FP's, GP's. Symposium, Feb. 22-23, St. Louis, Missouri. **Sponsor:** Office of CME, Washington University School of Medicine, Box 8063, 660 So. Euclid, St. Louis, Missouri 63110. **Fee:** $120. **Reg. limit:** 150. **Credit:** AAFP Elective, 12 hours; AMA Category 1, 12 hours. **Contact:** Loretta Giacoletto. **Phone:** 314-454-3873.

*Internal Medicine*

**TB TODAY**
**For:** Internists, FP's, GP's. Symposium, Feb. 15-16, St. Louis, Missouri. **Sponsor:** Office of CME, Washington University School of Medicine, Box 8063, 660 So. Euclid, St. Louis, Missouri 63110. **Fee:** $120. **Reg. limit:** 150. **Credit:** AAFP Elective, 12 hours; AMA Category 1, 12 hours. **Contact:** Loretta Giacoletto. **Phone:** 314-454-3873.

*Neurology*

**NEUROLOGY, PART I, BASIC**
**For:** Neurologists, Psychiatrists. 5½-day Lecture, Feb. 26, Chicago. **Speaker:** Neil Allen, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 So. Wood St., Chicago, IL 60612. **Fee:** $250. **Reg. limit:** 150. **Credit:** AMA Category 1, 44 hours. **Contact:** Robert Baker, MD. **Phone:** 312-733-2800.

*Psychiatry*

**TOPICS IN PSYCHOSOMATIC AND BEHAVIORAL MEDICINE**
**For:** Psychiatrists, primary care physicians. Lecture, Feb. 27-28, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School, Towsley Center for CME Ann Arbor, Michigan 48109. **Fee:** $120. **Reg. limit:** 350. **Credit:** AAFP Prescribed, 14 hours; AMA Category 1, 14 hours. **Contact:** Floyd Pennington. **Phone:** 313-764-2287.

*Psychiatry*

**SYSTEMS AND STRATEGIES IN FAMILY THERAPY**
**For:** Psychiatrists. Lecture, Feb. 21, 1:00-4:00 p.m., Forest Park. **Speaker:** Peggy Papp, ACSW. **Sponsor:** Riveredge Hospital Foundation, 8311 W. Roosevelt Road, Forest Park, IL 60130. **Fee:** $15. **Credit:** AMA Category 1, 3 hours. **Contact:** Susan Cosgrove. **Phone:** 312-771-7000.

*Surgery*

**SPECIALTY REVIEW COURSE IN THORACIC SURGERY**
**For:** General and Cardiothoracic Surgeons. 6-day lecture, Feb. 13, Chicago. **Speaker:** Sidney Levitsky, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 So. Wood St., Chicago, IL 60612. **Fee:** $250. **Reg. limit:** 200. **Credit:** AMA Category 1, 48 hours. **Contact:** Robert Baker, MD. **Phone:** 312-733-2800.

*Surgery*

**SPECIAL REVIEW COURSE IN NEUROLOGICAL SURGERY**
**For:** Neurosurgeons, Neurologists. 10-day lecture, Feb. 2, Chicago. **Speaker:** Leonard Kranzler, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 So. Wood St., Chicago, IL 60612. **Fee:** $425. **Reg. limit:** 250. **Credit:** AMA Category 1, 104 hours. **Contact:** Robert Baker, MD. **Phone:** 312-733-2800.

## *Cancer—Educational Materials*

**A variety of reprints, motion pictures (8mm and 16mm), tapes, slides, and exhibits are available from the American Cancer Society's Illinois office. That agency also maintains a speakers bureau. Topics covered include both physiological and psychological aspects; material is available to meet the needs of physicians, nurses, and patients.**

**For full information, write to . . .**
**Illinois Division, Inc.**
**American Cancer Society**
**37 South Wabash Avenue**
**Chicago, IL 60603**

**Introduction to CME Techniques**

**Two-day intensive workshop, Dec. 1-2. For: Hospital DME's, Program Chairmen, Medical Faculty, CME Planners. Leaders: Donald F. Pochyly, M.D., and Leonard S. Stein, Ph.D. Sponsor: ICCME. Oak Brook Hyatt House, Oak Brook, IL. Credit: AMA and IL license Category 1, 14 hours. Contact: Diane Wolniewicz, ICCME, 55 E. Monroe, Chicago 60603. Phone: (312) 236-6110.**

## *ATTENTION: CME PLANNERS*

**ICCME can help you build a high-quality CME program, worthy of accreditation, to help your colleagues satisfy the new Illinois Mandatory CME Law.**

**ICCME offers:**

***How to Start a CME Program* and other publications**

**Informal consultation by our staff**

**The "Workshop on CME Leadership" for leaders of hospital medical staffs and medical societies**

**The Illinois Hospital CME Consultation Service**

**Take advantage of *your* State Society's *unique* Council. For information, write or call:**

**Illinois Council/CME**
**55 E. Monroe, Suite 3510**
**Chicago, IL 60603**
**(312) 236-6110**

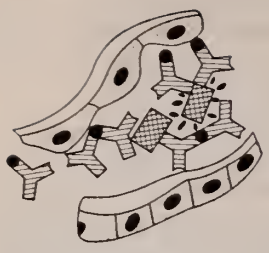
## MEDICINE FOR TODAY

***Winter Sessions***

**For: Family Practitioners (emphasis on Cardiology, Gynecology, Endrocrinology, Pulmonary). 30th Annual Postgraduate Program of the Illinois Academy of Family Physicians. CME Credit: AMA Category 1, 30 hours; AAFP Prescribed, 30 hours. Fee: $100, members; $110, non-members. Schedule includes:**

***Belleville*—Feb. 22; Mar. 1, 8, 15, 22, 29**
***Berwyn*—Feb. 21, 28; Mar. 7, 21, 28; Apr. 4**
***Bererly*—Feb. 21, 28; Mar. 7, 21, 28; Apr. 4**
***Centralia*—Feb. 21; Mar. 7, 21**
***Champaign*—Mar. 1, 15, 29**
***Chicago Nearwest*—Feb. 21, 28; Mar. 7, 21, 28; Apr. 4**
***Chicago North*—Feb. 21, 28; Mar. 7, 21, 28; Apr. 4**
***Chicago Southwest*—Feb. 21, 28; Mar. 7, 21, 28; Apr. 4**
***Harvey*—Feb. 21, 28; Mar. 7, 21, 28; Apr. 4**
***Hinsdale*—Feb. 21; Mar. 7, 21**
***Melrose Park*—Feb. 21, 28; Mar. 7, 21, 28; Apr. 4**
***Park Ridge*—Feb. 21, 28; Mar. 7, 21, 28; Apr. 4**
***Peoria*—Feb. 22; Mar. 8, 22**
***Rockford*—Mar. 1, 15, 29**
***Rock Island*—Feb. 22; Mar. 8, 22**
***Springfield*—Mar. 1, 29**

**For complete information, contact: Illinois Academy of Family Physicians, 1200 Harger Road, Suite 405, Oak Brook, Illinois 60521. Phone: 312-325-8502.**



# Seminars In Immunopathology and Oncology

RICHARD J. ABLIN, PH.D., CONTRIBUTING EDITOR

# Immune Complexes and Human Disease

BY BRIAN S. ANDREWS, BSc (Med) AND RONALD PENNY, M.D./SYDNEY, AUSTRALIA

*This is the conclusion of a three part special overview series for the "Seminars in Immunopathology and Oncology." In part one, Doctors Pennsy and Andrews delineated the historical background to immune complex research. Part two, exploring detection of immune complexes, was published in the September* IMJ. *This concluding portion considers general management criteria.*

## General Management of an Immune Complex Disorder

An IC disease should be suspected either by the distribution or nature of the basic immunopathologic process. Specific questions should be raised regarding a possible underlying disease (SLE, ulcerative colitis); possible Ag (s) involved (drugs, tumor infectious agents) and initiating factors (drugs, UV-irradiation).

Once suspected, an IC disease should be confirmed by demonstration of the complex in serum and the finding of a consistent histopathologic picture coupled with identification of Ig and C components in the tissues. Examination of serum for circulating ICs should include a combination of techniques to identify functional characteristics of the complex (es). If ICs are demonstrated in one site, a careful evaluation of other high risk sites (kidney, skin, joint, eye) should be made.

As indicated (Table 6) there are both theoretical and practical approaches to the management of a patient with circulating ICs; the approach depends on disease severity and if indications for specific therapy exist. First, the composition of the IC may be modified by manipulating the Ag. This may be achieved by avoiding exposure to the Ag, eliminating an infectious agent or diminishing the inflammatory response whereby autoantigens may be liberated in the serum. The latter applies specifically to active SLE, where the use of corticosteroids may reduce the release of cellular DNA at the inflammatory site. In theory, specific enzymic destruction of Ag by penicillinase or DNase may play a future role. If the Ag can be identified, administration of excess nonpathogenic Ag may reduce the half-life of the circulating or tissue IC. In experimental chronic serum sickness, administration of excess Ag aided in clearance of Ag from



BRIAN S. ANDREWS, BSc(Med), MB, BS, FRACP, is an assistant professor of medicine affiliated with the University of Virginia. He graduated MB BS, from the University of Sydney Medical School in Sydney Australia. Doctor Andrews is a fellow of the Royal Australian College of Physicians.



RONALD PENNY, M.D., F.R.A.C.P., F.R.C.P.A., is an associate professor of medicine and director of the department of Immunology at the University of New South Wales at St. Vincent's Hospital in Sydney, Australia. Doctor Penny initiated his research in immunology and immunopathology at the Institute of Cancer Research at New York's Columbia University.

**Abbreviations**

| | |
|---|---|
| Ab | Antibody |
| Ag | Antigen |
| C | Complement |
| IC(s) | Immune Complex (es) |
| Ig | Immunoglobulin |
| GN | Glomerulonephritis |
| MPS | Mononuclear phagocytic system |
| PEG | Polyethylene glycol |
| PMN | Polymorphonuclear leukocyte |
| RA | Rheumatoid arthritis |
| RF | Rheumatoid factor |
| RIA | Radioimmune assay |
| SLE | Systemic lupus erythematosus |

the glomerulus.[4] Further, excess Ag may lead to reduced Ab synthesis by producing high dose tolerance, possibly activating suppressor T-cells. Transfer factor has been employed in anergic patients with persistent hepatitis B-induced hepatitis and IC disease.[105] It was proposed that clearance of intracellular virus would reduce the overall Ag load and subsequent pathogenetic IC formation.

Secondly, the Ab may be modified by specific drugs. Corticosteroids[182] and immunosuppressive agents[183] will reduce Ig synthesis over a period of time. Antibody may possibly be destroyed by a drug such as penicillamine which is effective in severe RA and is associated with a reduction in serum IgG and IgM and RF activity.[184] Conversely, an increase in Ab level may result from infusion of specific Ab or by immunization. It could be anticipated that Ab excess complexes would be formed with rapid clearance from the circulation. This presupposes that the more phlogistic complexes will be cleared by a mononuclear phagocytic system which is functioning normally, which may not be so.

Thirdly, ICs may be removed directly from serum by plasmapheresis.[58,96,185,186] This technique has been applied successfully to the management of patients with active SLE, mixed cryoglobulinemia and "blocking factors" in serum associated with malignant disease. In addition, specific autoantibodies can be removed in Goodpasture's Syndrome and in thrombocytopenic purpura, allowing easier control of the disease process. In the future, plasmapheresis incorporating a selective removal system for complexes may be possible.

Fourthly, mononuclear phagocytic function may be increased by drugs such as Levamisole which may enhance clearance of larger C-fixing ICs.[187]

In practice, however, the management of IC disorders involves modification of the biological sequelae which follow IC formation (Table 6).

**Table 6**[4,13,14,35,58,96,105,182-192]

**Approaches to the Management of Immune Complex Disorders**

A. *Modify Antigen-Antibody Composition of the Complex*
   1. *Antigen*—Avoid exposure; eliminate microorganism; decrease release of auto-antigens e.g. DNA; destroy antigen[d], e.g. penicillinase, DNase; transfer factor; administer excess antigen.[d]
   2. *Antibody*—Decrease antibody production; increase antibody level;[d] destroy the antibody e.g. penicillamine.

B. *Remove the Immune Complex*
   1. Plasmapheresis or selective removal[d] incorporating plasmapheresis.
   2. Increase mononuclear phagocytic function e.g. Levamisole.

C. *Limit Biological Sequelae Produced by Immune Complexes*
   1. Limit interaction with cellular receptors, e.g. block Fc receptors on platelets, eosinophils, PMNs and mononuclear phagocytes by infusing Fc fragments.[d]
   2. Block effects of cell-bound complexes e.g. limit platelet aggregation and vasoactive amine release by salicylates and dipyridamole.
   3. Reduce effects of released mediators e.g. antihistamines, antiserotonins.
   4. Reduce microvascular coagulation and increase clearance of fibrin by heparin and fibrinolytic therapy respectively.
   5. Inhibit prostaglandin synthesis by salicylates or Indomethacin.
   6. Reduce overall inflammatory response e.g. corticosteroids.

[d]Theoretical approaches.

The therapy depends on the severity of the disease process and the organ(s) involved, in particular, brain, retina, heart, and kidneys. With severe inflammatory disease corticosteroids are generally indicated to reduce the overall inflammatory response; their exact mechanism of action is not clearly understood. In addition, immunosuppressive agents (cyclophosphamide, chlorambucil, azathioprine) may be helpful in reducing Ab synthesis and the cell-mediated immune response, but particularly in their steroid-sparing capacity or for control of the disease process if corticosteroids alone are ineffective.[182,183]

When the inflammatory process is not severe and does not significantly compromise vital organ function, other alternatives are available. The effect of cell-bound ICs may be modified by reducing platelet aggregation with the subsequent release of nucleotides and vasoactive amines; this is achieved by salicylates (300-600 mg/day) with or without dipyridamole (25 mg qid).[188] To reduce the effect of histamine and serotonin which may be released from basophils, mast cells and platelets, cyproheptadine may be effective (4 mg tid); this agent blocks both histamine and serotonin binding.[20,29] With any inflammatory process there is usually some element of microvascular coagulation and fibrin(ogen) deposition. Heparin will reduce the former[189] while fibrinolytic therapy will aid clearance of the latter. Fibrinolysis may be achieved by a combination of phenformin (25 mg qid) and an anabolic steroid, ethyl estranol (2 mg qid) or possibly by streptokinase if impaired fibrinolysis and fibrin deposition are marked.[190] Prostaglandins may exacerbate the inflammatory process; their formation can be reduced by drugs which inhibit prostaglandin synthetase (salicylates or indomethacin).[191]

In many situations, however, the nature of the Ag involved in IC formation is unknown with the treatment remaining empiric. Every attempt should be made to identify possible initiating Ag's or events which trigger IC formation, in order to avoid them in the future. ◄

---

*This concludes our three part series on immune complexes and human disease. A complete list of references is available upon request to: Illinois Medical Journal, 55 E. Monroe, Suite 3510, Chicago 60603.*


CHIEF PHYSICIAN

Full time position with major South Chicago industrial concern, located conveniently to city or south suburban living.

Complete in-plant facilities with nearby consultative and hospital services available.

In addition to attractive compensation, this position carries an excellent corporate benefits package.

Please reply with curriculum vitae and/or professional history to Box 932, IMJ, 55 E. Monroe, Suite 3510, 60603.

An Equal Opportunity Employer M/F

orthopedic SURGEON

Part or full time Orthopedic Surgeon for a large chronic disease and rehabilitation institution, with a 200 plus bed acute hospital. Close university affiliation with residency program. Competitive salary and liberal fringe benefits.

All replies with C.V. to:
JACK SOBEL, M.D., F.A.C.P.
MEDICAL DIRECTOR and CHIEF OF STAFF

OAK FOREST HOSPITAL
15900 SOUTH CICERO AVENUE
OAK FOREST, ILLINOIS 60452

An Equal Opportunity Employer M/F




# ILLINOIS WANTS YOU!!

THE DOCTOR'S JOB FAIR
10:00 a.m.-4:00 p.m.
December 10, 1978
Sheraton-Oakbrook
1401 W. 22nd St.
Oak Brook, Illinois

Meet with the representatives from Illinois Communities . . . and YOU WILL BE SURPRISED at what they have to offer! Over the past year, 20 of your colleagues have found the community of their choice through the DOCTOR'S JOB FAIR.

For more information, please complete and return the attached form.

---

7th ANNUAL DOCTOR'S JOB FAIR

**PHYSICIAN RECRUITMENT PROGRAM**
Illinois State Medical Society
55 East Monroe — #3510
Chicago, Illinois 60603

Include Hotel Reservation Card _____

NAME _____

ADDRESS _____

CITY, STATE, ZIP CODE _____

# Physician Recruitment Program

*In an effort to reduce the number of towns in Illinois needing physicians, the Physician Recruitment Program and the Doctor's Job Fair, are publishing synopses in the Journal.*

*Physicians who are seeking a place to practice or who know of any out-of-state physicians seeking an Illinois residence are asked to notify the Program.*

*Any areas wishing to be listed should contact: Mrs. E. Duffy, Physician Recruitment Program, ISMS, 55 E. Monroe, Suite 3510, Chicago, 60603.*

***Announcing . . .***

## The 1978 DOCTOR'S JOB FAIR
## December 10, 1978
## Sheraton-OakBrook Hotel

*For further information contact:*

Physician Recruitment Program
Suite 3510 — 55 E. Monroe
Chicago, IL. 60603
312-782-1654

**ARCOLA:** Wanted-American trained F.P. to join established F.P. in active practice. Must do some O.B. Guaranteed salary and benefits. Eventual partnership. Robert N. Arrol, M.D., 126 S. Locust, Arcola, 61910. (217) 268-4444, or 268-4404. (12)

**ATKINSON:** Due to recent death of town's physician, a modern clinic with all facilities is available to a family physician who wants security and a wonderful place to practice. Hammond Henry Hospital only 8 miles away. Excellent grade and high schools and near Black Hawk Junior College. 30 miles to Quad City area, 140 miles to Chicago and 60 miles from Peoria. All recreational facilities nearby. CONTACT: John W. Ellis, Mayor, Atkinson 61235. (309) 936-7566. (12)

**AURORA:** Opening in General Internal Medicine with 40 man group. Complete office facilities. Good starting salary. Contact: L. E. Snyder, M.D., 1870 W. Galena Blvd., Aurora 60506. (312-859-6700) (1)

**CARBONDALE:** G.P., F.P., or Internist for health service at prominent university which includes a school of medicine. Scenic recreational area combining the virtues of small town living with the cultural and shopping assets of a large metropolitan area. Attractive salary, 40 hour work week and generous fringe benefits. IL license required. A.A./E.O.E. For further information send vitae to Don Knapp, M.D., Medical Director, SIU-C Health Service, Carbondale, IL 62901. (3)

**CHICAGO:** Major Chicago based retailer seeking corporate physician. Up-to-date, modern facilities, regular hours and comprehensive employee benefits make this a very desirable position. Please send resume with salary requirements. Contact: Professional Employment Director, Sears, Roebuck & Co., D/707-2, Chicago 60684 (1)

**FAIRFIELD:** Population 6,500. Opening for OB-Gyn board eligible or certified and general practitioner to join group of two physicans (F.P. and surgeon). Complete office facilities, excellent salary and fringe benefits, opportunity to become full partner. Near university, junior college locally. Good fishing, hunting, cultural opportunities, all churches. Contact: S. W. Konarski, M.D., 401 East Center Street, Fairfield 62837. (618) 842-2187. (3)

**HARVARD:** An internist, OB-GYN for Northern Illinois commuter suburb. New hospital, good schools, guaranteed salary and benefits based on qualifications. Close to resort areas. A solid community economically. Contact: Dr. John P. Hill, 502 N. Hart, Harvard 60033. (815-943-5151) (1)

**LA GRANGE:** Western suburb of Chicago, medium sized hospital. Opening for Director of medical affairs, new position, full time. Work with medical staff on CME, medical staff affairs, Family Practice Residency Program and University affiliation. Contact, Administrator, 312-352-1200. (2)

**LISLE:** Physician needed to assist me in handling my very extensive private family practice. Salary open, good opportunity for this relationship to merge into a partnership association. CONTACT: M. Sinkovits, 4513 Lincoln Ave., Lisle 60532. (312) 968-2735. (12)

**MACOMB:** GP-FP 12 month contract practice—University Health Service. Outpatient clinic—no OB, Surgery. Fringes include hospitalization, paid vacation, retirement, etc. Approximately 13,000 students, city 23,000. Competitive negotiable income. Equal opportunity affirmative action employer. Contact: C. E. Hughes, M.D., Director BEU Health Center, WIU, Macomb 61455. (1)

**OSWEGO:** Family physician or internist to join group of four in a small town primary care clinic. Two full-service hospitals nearby. One hour west of Chicago. Dr. A. Haan, Oswego, 60543. (312) 554-8431. (11)

**PAXTON:** Paxton Community Hospital is enlarging its medical staff due to expansion of the facility and has openings for Family Practitioners to locate in the community. A 30 bed, general short term acute hospital offers full services to the community except for OB. The hospital, in East Central Illinois, is approximately two hours from Chicago, St. Louis, and Indianapolis, and 30 minutes from University of Illinois. The hospital is fully accredited by the JCAH. Contact Mr. David Polge, Administrator, Paxton Community Hospital, 651 East Pells, Paxton 60957. Phone 217-379-2387. (12)

**PEORIA:** Economical sound central Illinois community of 250,000 situated in picturesque river valley has need for family physicians and general internists to practice in a 300 bed community hospital affiliated with the University of Illinois, College of Medicine. Office space and financial assistance available. "A GOOD PLACE TO PRACTICE GOOD MEDICINE." Contact: John A. Smith, Administrator, Proctor Community Hospital, 5409 N. Knoxville, Peoria 61614. (309-691-4702) (3)

**WEST FRANKFORT:** Population 10,000, county 42,000. Coal mining growth area (1,200 new jobs). Offices available near hospital. On I57/24 in Southern Illinois. Major university near. Good highways, and recreation. Need OB-GYN, IM-CV, IM-GP and FP. Financial assistance. Contact: Wm. D. Palmer, Administrator, UMWA Union Hospital, 507 W. St. Louis St., West Frankfort 62896. (618-932-2155) (1)


**Weekend Workshop**

## Introduction to CME Technique

**An intensive weekend workshop *FOR* Hospital DMEs and Program Chairmen, Medical Faculty, other CME Planners**

**December 1-2, 1978** **Friday 1:30 P.M. to Saturday 5:15 P.M.**

**Oak Brook Hyatt House, Dorset Room, Oak Brook, IL**

This workshop takes account of the findings of both research and experience that physician continuing education is most satisfying if it occurs both individually and in groups at organized CME programs planned by the learners in the hospital setting. The workshop's overall goal is to offer an introduction to the basic elements of educational planning as they apply to CME.

**For further details on program, schedule, and cost; write or call:**

**Illinois Council on Continuing Medical Education**
**55 East Monroe, Suite 3510, Chicago, Illinois 60603**

**Telephone: (312) 236-6110**

NONPARTISAN

# IMPAC

**ILLINOIS MEDICAL POLITICAL ACTION COMMITTEE**
55 East Monroe Street
Chicago, Illinois 60603
312/782-1963

Dear Doctor:

The election that this page has mentioned so frequently in the past months is over. All of the votes are cast and the outcome secure. I hope that some of you took IMPAC's advice and got involved in the campaign of the candidate of your choice and I'm sure that win or lose, that involvement along with the vote you cast on November 7th provided you with a meaningful and memorable experience---because you cared.

Perhaps those of you who didn't get involved or didn't vote can't understand the meaning of that experience; you care, but not as much as one who sacrificed his time, talents, sweat and heart. You probably are wondering what the big hub-bub is all about---after all, "it was *only* an election".

"*Only*" an election" - *only* the process by which we determine our own fate

*only* the way in which we pick our leaders

*only* the foundations upon which our republic was built

*only* the way in which the people impact their government.

*Only...*

It was once said that "Here sir, the people rule". But *only* with their efforts towards electing responsible legislators and *only* with their votes.

The blessing of democracy is that you always have another chance. There are less than two years until the 1980 primary, so you can start now to find out what it is all about. No one will thank you, but you'll discover what many have discovered before you---the excitement of invoking your rights as a citizen. Think about it, it's *only* a year and a half away.

Herbert Sohn, M.D.

Herbert Sohn, M.D.
Chairman

Contributions are not limited to the suggested amount. Neither the Illinois State Medical Society nor the AMA will favor or disadvantage anyone based upon the amounts of or failure to make pac contributions. Copies of IMPAC & AMPAC reports are filed with and are available for purchase from the Federal Election Commission, Washington, D.C. Contributions are subject to the limitations of FEC regulations, Sections 110.1, 110.2 & 110.5. (Federal regulations require this notice.) IMPAC reports are also filed with the State Board of Elections, and are or will be available for purchase from the State Board of Elections, 1020 South Spring Street, Springfield, Illinois 62704.

# Doctor's News

**SPEAK UP FOR CHILDREN**—The American Academy of Pediatrics has announced a national program in public education on child health issues. Initiated as a response to the declaration from the United Nations designating 1979 the International Year of the Child, the AAP will launch a four-pronged attack on public consciousness. Accident prevention, health education, immunization and nutrition will receive great emphasis in AAP efforts this year, according to Saul J. Robinson, M.D., AAP president.

In a related note, the September 8 issue of the Journal of the American Medical Association included an article reporting results of a physician poll on child abuse. The authors stated that while more than half of those responding reported seeing at least one identifiable sexually abused child annually, two-thirds of those polled said that they sometimes did not report these cases to authorities, because they felt that the cases could be better handled privately, and feared harm to the family. The other third noted a dissatisfaction with the manner in which state social service agencies handled such cases.

**ALCOHOLISM UPDATE**—A recent report from Alcoholics Anonymous cites an apparent demographic shift. A news release from Warsaw, Poland, reports that "the largest survey ever made of recovered alcoholics shows a nearly 50% increase since 1974 in the percentage of people under 30 years of age in Alcoholics Anonymous." The report also states that 32% of current AA members internationally are female. The data were released at the 32nd International Congress on Alcoholism and Drug Dependency, and refer to a survey of over 17,000 AA members worldwide.

In a related note, ISMS members are reminded that the ISMS Scientific Speakers Bureau now includes a roster of experts in alcoholism education. Their presentations are a part of a special program funded in part by a grant from the Illinois Department of Mental Health and Developmental Disabilities, Division of Alcoholism. Illinois' hospitals, county medical societies and medical schools are encouraged to sponsor alcoholism programs for their staff. For further information, please contact the ISMS offices, 55 E. Monroe, Suite 3510, Chicago, 60603.

**DEPT. OF R & E ANNOUNCES NEW OFFICES**—The Illinois Department of Registration and Education has announced that they will be moving their Springfield offices sometime late in 1978. The new address for correspondence to the Springfield office will be: 320 W. Washington Street, Springfield, 62786. The new telephone number in Springfield will be 217-785-0800. The Department's Chicago offices are not affected by this move. The Department has not yet announced the effective date of that move, other than to note that it will occur before year's end.

**ICCME WORKSHOP ANNOUNCED**—The Illinois Council on Continuing Medical Education will hold its annual workshop, "Introduction to CME Technique," at the Oak Brook Hyatt House on December 1 and 2, 1978. The workshop is designed for directors of medical education, program chairman, medical faculty and other CME planners. For further information, please contact ICCME, (312) 236-6110.

**PHYSICIANS IN THE NEWS**—The Illinois Chapter of the American Academy of Family Physicians elected new officers at their 30th annual meeting in Chicago. The new officers include: **Eugene Vickery, M.D.,** Lena, president-elect, **Leonora Nash, M.D.,** Moline, director, and **Eugene Welter, M.D.,** Aurora, vice president. **Delburt H. Nelson, M.D.,** Oak Lawn, was installed as IAFP president at that meeting. . . . The Illinois Chapter, American Academy of Pediatricians, recently elected **James P. Paulissen, M.D.,** Wheaton, and **James H. Cravens, M.D.,** Quincy, to join their Executive Committee for three year terms.

Three Illinois physicians received special honors in their fields this month. **James G. Dobbie,** a Chicago Ophthalmologist, received the American Academy of Ophthalmology annual honor award for outstanding service to his profession. **John B. O'Connell, Jr., M.D.,** a fellow in the cardiology section at Loyola University Medical Center in Maywood, received the Illinois Society of Internal Medicine Norris L. Brookens award, which is awarded each year to an outstanding internal medicine resident. **Roman W. Kozakiewicz, M.D.,** a Chicago physician on the staff of Saint Mary of Nazareth Hospital Center, was recently named a fellow of the American Academy of Family Physicians.

The American College of Cardiology recently announced the names of 19 Illinois cardiology specialists who have been awarded the status of Fellows in that organization. The new fellows are **Emanuel R. Arbel, M.D.,** Chicago, **Antonio Q. Chan, M.D.,** Oakbrook Terrace, **Francis S. Cheng, M.D.,** Rolling Meadows, **Danilo A. Deano, M.D.,** Chicago, **David L. Fishman, M.D.,** Maywood, **Frank J. Forlini, Jr., M.D.,** Rock Island, **Julius M. Gardin, M.D.,** Chicago, **Madam Lal Gupta, M.D.,** Galesburg, **Hossein Keivan, M.D.,** Blue Island, **Bart R. Mayron, M.D.,** Chicago, **William L. Millman, M.D.,** Oak Park, **John P. Monteverde, M.D.,** Skokie, **Thomas E. Murphy, M.D.,** Evanston, **Paul Naffah, M.D.,** Elmwood Park, **Karoon Nititham, M.D.,** Evanston, **Gerald R. Peterson, M.D.,** Rockford, **James A. Schoenberger, M.D.,** Chicago, **Ronald L. Van Der Horst, M.D.,** Glencoe, and **James W. Ziccardi, D.O.,** Chicago.

**APPENDECTOMY LINKED TO LARGE BOWEL CANCER**—Results of a study conducted at the University of Texas M. D. Anderson Hospital and Tumor Institute reported at the 12th International Cancer Congress in Argentina have hypothesized a correlation between cancer of the large bowel and previous appendectomy. The study, conducted by the National Large Bowel Cancer Project, found that of 917 patients treated for colon and rectal cancer during the period 1963-73, 35% had had prior appendectomies. (The general population has a 15% incidence of appendectomy). In reporting results, Birger Jansson, a biomathematician associated with M. D. Anderson who coordinated the study, said, "Many persons have the appendix incidentally removed during other types of abdominal surgery . . . such non-indicated removal should be questioned."

**DANGEROUS DRUGS UPDATE**—The Illinois Dangerous Drugs Commission voted at the October 20, 1978, meeting to add pentazocine (Talwin) to the list of designated products in Illinois. This decision, which took effect November 10, requires that all prescriptions for pentazocine be written on the official triplicate prescription form. The Commission had voted at their August meeting to designate pentazocine as a Schedule II substance.

## *President's Page*



# Disapprove Concept, Not Method

Blue Cross/Blue Shield's unsuccessful bid to attach a "medical necessity" rider to its policies has focused attention on the ill-advised concept of retrospective review by carriers to justify denial of payments.

Following state Insurance Department "disapproval" of the controversial rider, the Senate Insurance Committee last month held public hearings on the issue and the Department's approval process for all riders. The hearing raised some disturbing points.

"Disapproval" was a victory for ISMS which lead the storm of protest that prompted Insurance Department action on the rider which would have denied payment for services the carrier deemed not medically necessary. However, at the hearing it was strongly suggested that the method of applying retrospective denial—not the concept itself—was improper. If an acceptable method of application had been used, the rider might have remained in effect.

Regardless of how it is applied, retrospective denial contains an inherent unfairness to both physician and patient. When payment is denied after-the-fact, a patient logically can be expected to question the prescribed treatment. Subsequent damage to the physician-patient relationship could be irreparable. In addition, this type of review places the patient at risk for conceivably greater expenses.

Carriers seem bent on ignoring the effectiveness of concurrent review carried out in all hospitals by Utilization Review (UR) committees. Because the entire staff has an opportunity to participate, UR serves as an educational as well as cost control process. UR is undeniably a peer review procedure. The same cannot be said for retrospective review by physicians who work for insurance carriers but do not practice medicine.

Hospital utilization review—required under PSRO in Cook County—has proven effective. A retrospective review by Blue Cross/Blue Shield of concurrently-renewed, PSRO-approved cases uncovered an incidence rate of only one in 10,000 that did not meet the carrier's criteria.

The benefits of concurrent review over the retrospective approach are obvious. The concept of retrospective denial—not the method of applying it—should be the basis of "disapproval."

David S. Fox, M.D., President

# CLASSIFIED ADVERTISING

## POSITIONS & PRACTICE OPPORTUNITIES

**FULL TIME PHYSICIAN** for Industrial Clinic in Skokie. Surgical experience needed. Salary negotiable. Must have Illinois license. Call (312) 674-4800, Mrs. McCubbin.

**OPPORTUNITIES FOR PHYSICIANS IN INDIANA**—There are several excellent openings among the Indiana State Hospitals at various locations throughout the state for psychiatrists and physicians of other specialties, at most experience levels. A newly-revised salary schedule offers a very competitive income plus a generous package of fringe benefits. An adjunct practice is possible beyond the regular working hours and on-call responsibilities. Please reply with a copy of the c.v. to: Farabee & Associates, Inc., P.O. Box 472, Murray, KY 42071 or call (collect) (502) 753-9772. Farabee is retained by the Indiana Department of Mental Health.

**EMERGENCY DEPARTMENT PHYSICIAN:** Become part of an expanding, dynamic multispecialty clinic in midwest university community of 100,000. Excellent salary, benefits. Write or call Medical Director, Carle Clinic, Urbana, IL 61801, (217) 337-3239.

**FAMILY PRACTITIONER**—To associate with one senior general practitioner and one surgeon in rural southern Illinois. Excellent educational system and recreation. Financially sound community. One hour from St. Louis. JCAH 72-bed hospital in Nashville. Association available now. Contact: T. K. Janssen, Administrator, Washington County Hospital, Nashville, Illinois, (618) 327-8236.

**ILLINOIS—PEORIA**—Interviewing career Emergency Physicians for full-time openings starting immediately and Jan. 1. Opportunity to join young ACEP oriented physicians' group in 550-bed Medical-Surgical Hospital affiliated with Peoria School of Medicine. Good specialty backup. Flexible scheduling. Superior compensation with liberal fringe benefits including malpractice. Contact H. T. Stratton, M.D.; Methodist Medical Center, 221 NE Monroe, Peoria, IL 61636; (309) 672-4974 or (309) 672-5501.

**PHYSICIAN WANTED.** Full or part time for fully equipped medical center. Large welfare practice. 2823 N. Clybourn, Chicago, Ill. 60618. Telephone—(312) 929-6999 or 664-3157.

**OCCUPATIONAL MEDICINE**—National corporation needs associate medical director in Skokie, Illinois; occupational medical experience desirable. Corporation dedicated to comprehensive health program for all employees; modern well equipped facilities; liberal fringe benefits include life and health insurance, excellent savings plan, malpractice insurance coverage, liberal vacation, holiday and sick leave policies, etc.; salary commensurate with position responsibilities, experience and professional training. Send resume in confidence to Box 935, c/o Illinois Medical Journal. An Equal Opportunity Employer.

**PHYSICIAN WANTED:** General medical services to be provided to psychiatric patients. Full and part-time positions available. Generous fringe benefits. Salary negotiable. 50 minutes from downtown Chicago. Contact Claude Roush, Superintendent, Manteno Mental Health Center, Manteno, Illinois 60950. (815) 468-3451.

**LOCUM TENENS—EMERGENCY MEDICINE**—available in our 100 hospitals; monthly scheduling is flexible and according to your preferences; malpractice is paid, excellent hourly income according to your flexibility and hours worked. Call toll free 1-800-325-3982, ext. 220 for details

**OPPORTUNITY IN FAMILY PRACTICE**—Two Board Certified Family Physicians need third physician. New office connected to new hospital (250 beds) with all ancillary and specialized services available. Any interested physicians please snd curriculum vitae to Link, Chapman & Associates, Inc., 1515 West Truman Road, Independence, Missouri 64050, or call collect 816-836-8200; 9:00 a.m. to 4:30 p.m.

**IN PATIENT CLINIC PRACTICE** at Illinois Developmental Centers; various locations. Monday through Friday, days only, no night or weekend call. Guaranteed income of $40,000-$50,000. Send CV to T. P. Cooper, M.D., 970 Executive Parkway, St. Louis, MO 63141, or call toll free 1-800-325-39B2.

**ORTHOPEDIC SURGEON** who desires to locate in a rural area of southern Illinois needed to serve two community hospitals. One hour from St. Louis. Good educational system for children. Excellent recreation. Reply: T. K. Janssen, Administrator, Washington County Hospital, Nashville, Illinois 62263.

**A PROGRESSIVE RURAL COMMUNITY** in midwestern Indiana desires to secure two or more general practitioners. Interested parties would find new schools, a new nursing home, new banks, good hospitals nearby, etc. A medical center with purchase option will be built to accommodate these physicians. Contact J. D. Piech, 1600 E. Liberty, Covington, Indiana. (317) 793-4818.

**ILLINOIS DEVELOPMENTAL CENTERS:** Background in primary care and psychiatry helpful; Interdisciplinary team approach. Monday-Friday, days only, nights or weekends optional; excellent remuneration; Illinois license required. Contact T. P. Cooper, M.D., 970 Executive Parkway, St. Louis, MO 63141 or call toll free 1-800-325-39B2, ext. 213.

**NEEDED:** Creative physician educator to assume an excellent position and opportunities as Associate Director of a Family Practice program which is part of a 30 physician residency. This center is located within the new Medical Tower adjacent to an 1150 bed teaching hospital in Indianapolis, Indiana. Excellent salary and benefits available. For further information, send C.V. to: Director of Family Practice Education, Methodist Hospital, 1604 North Capitol Avenue, Indianapolis, Indiana 46202.

**FAMILY PRACTICE SPECIALIST NEEDED** in busy expanding, future oriented, multispecialty clinic to participate in development of new department; three department members plan curriculum for AAFP approved family practice residency; ample opportunity for developing, fulfilling, primary practice and personal development; located in university community; liberal financial and fringe benefits. Contact: Medical Director, Carle Clinic, Urbana, IL 61801. (217) 337-3239.

**MATTOON-CHARLESTON, ILLINOIS**—Sara Bush Lincoln Health Center Emergency Department has openings for qualified physician; guarantee $50,000-$55,000 with ideal working conditions and schedule. Send curriculum vitae to Stephen Allin, M.D., Emergency Department Director, P.O. Box 372, Mattoon, Illinois 61938 or call toll free 1-800-325-3982 for details.

**EMERGENCY PHYSICIAN—WOOD RIVER, ILLINOIS,** St. Louis area hospital treating 15,000 patients annually. Excellent nursing staff, modern facility. Flexible scheduling, 2/24 hour shifts a week. Remuneration from $47,000. Paid malpractice insurance. Send curriculum vitae to Judy Patterson, M.D., Director of EMS, Wood River, IL 63136 or call toll free 1-800-325-3982.

**PHYSICIAN NEEDED** for resort community in magnificent sunbelt setting. Enjoy superb golf, tennis, sailing, riding, fishing, hunting and all water sports. Start with a guaranteed salary and benefit package. No investment required, but in two years, you can own your own practice including medical and office equipment and office furniture purchased at book value. Benefits include liberal vacation. Study time with travel expenses paid. Paid malpractice, health, accident and life insurance. For more information, write Don Small, Fairfield Bay Medical Center, Box 3008, Fairfield Bay, Arkansas 72088, or call toll-free 800/643-9790 or 643-9791 (in Arkansas, call 501/884-6334).

## FOR SALE, LEASE OR RENT

**MEDICAL OFFICE SUITE FOR RENT,** Lincoln-Belmont Bldg. 715-1200 square feet, available at once in full service, elevator, active professional building. Call Gary Solomon, (312) 334-5400.

**SUITE TO LEASE** for Internist, Pediatrician, Psychologist, Psychiatrist or other medical practice. Suite is located in a high quality building with a growing medical community situated across from a major hospital. The complex already includes an outstanding lab, X-ray facility, pharmacy and 16 professionals. Arrangement provides flexibility for the new tenant to share a suite with an existing practice, to have office built in newly created bare space and to participate in the ownership and direction of the complex. STRONG Property Managers, Ltd. Agents, 201 W. Springfield, Champaign, IL 61820. (217) 356-2617.

**LISLE-MEDICAL SUITE** available in prestigious modern building located on Rt. 53 in Lisle. X-ray facilities on premises. Zone controlled heating and air conditioning. Ample parking. Call 969-2850.

**FOR SALE:** 100 Mili-amp X-ray machine complete with fluoroscopic screen and developing tanks. Contact Wilson L. DuComb, M.D., 560-Bth Street, Carlyle, Illinois 62231. Phone (618) 594-3451.

**MEDICAL SUITES AVAILABLE,** near north side of Chicago, Logan square area, (312) BE5-7000, Mr. Fein.

**INGALLS MEMORIAL HOSPITAL**—New professional building, Harvey, Ill. Suites to doctors specifications. Housekeeping, maintenance, utilities included. Ample patient parking. Enclosed walkway to hospital. McKey & Poague Agents. (312) 331-4226.

**OPPORTUNITIES FOR PHYSICIANS IN CHICAGO WESTERN SUBURB:** Unique new medical office condominiums under construction in Wheaton/Carol Stream. Anticipated occupancy February, 1979. Opportunity to lease, purchase or lease with an option to purchase. Situated adjacent to existing Professional Park housing 35 physicians. Call (312) 665-9777 for details or brochure.

**SPACIOUS NORTHSIDE LAKEVIEW AREA** medical office for rent. Newly remodeled. Five examining rooms, carpeted. Large furnished waiting room. Available now. Interested in Spanish speaking doctors only. Growing Spanish speaking area. Near Ashland-Lincoln and Belmont. Pharmacy space also available, if desired. Please contact: Dr. Pedro O. Cabrera (Dentist) at 1442 W. Belmont or call 528-006B.

**SUB-LEASE** active general practice of 30 years in northwest suburb of Chicago. Five rooms fully equipped—excellent location in medical building with pharmacy—furniture, instruments, and records. Immediate possession. Call (312) 697-4372.

**FOR THE INDIVIDUAL OR GROUP** desiring the ultimate piece of residential property in the western suburban area. Eleven plus acre estate in Naperville with nine hundred plus foot frontage on the Du Page River. Estate landscaped and covered with hundreds of beautiful, mature oak and blue spruce trees. Price $6B0,000. Shown by appointment. 355-8998.

**RANCH-STYLE MODERN MEDICAL-DENTAL BUILDING FOR RENT** or sale: Customized facilities to meet every medical and dental need. Ideal for family physician or group practice. 1500 to 2500 sq. ft. available. Armitage and Damen area, Chicago. Near St. Mary of Nazarene Hospital. Excellent location for neighborhood practice. (312) 472-5126 or 338-9347.

**SALE OR LEASE**—Eye or ear nose throat, or both—retiring—mod. one story brick bldg.—9 rms., 3 lavs., carpeted—wood panelled—central A.C.—practice—office—equipment—surgical instruments—gas ht.—ample parking—only e-ent man in town—on Main Street—11 hospitals—38 years practice—will introduce—will negotiate. Call or write E. J. Sodaro, M.D., 7620 Madison Street, Forest Park, Illinois 60130. Phone: 312-366-1950.

**RUSSIAN TREASURES**—private—Antique jewelry, silver enamel and miniature boxes and tableware, icons, brass SAMOVAR, unique oil paintings and more. (312) 561-4312.

## SITUATIONS WANTED

**31 YEAR OLD MALE** 2 years post graduate training. Four years of emergency practice. High volume and high trauma in the four years. BLS provider BLS instructor ACLS provider seeking fee for service with partnership. C.V. on request. Available now. P.O. Box 425, Western Springs, IL 60558.

**31 YEAR OLD MALE** 2 years post graduate training 4 years of emergency practice. BLS, ACLS provider. BLS instructor ER experience in high volume and high trauma in the four years. Member AMA, ACEP. Seeking ER directorship. CV on request. P.O. Box 425, Western Springs, IL 60558.

**INTERNIST,** 29, FMG, seeks relocation. Available IMMEDIATELY. Write Box 936, c/o IMJ, 55 E. Monroe, Suite 3510, Chicago 60603.

**SERVICES RENDERED:** Professional typing from rough draft or dictation from cassettes or stenorette reel. Satisfaction guaranteed. 312/485-7650 or 352-5698. 8901 Southview, Brookfield, IL 60513.

## MISCELLANEOUS

**PECAN HALVES—WALNUTS—SLICED ALMONDS!** Three-quart sampler, $9.95 postpaid; Canecreek Farm, Box 2727-MJ, Cookeville, TN 38501.

## GUARANTY FUND CERTIFICATE

**GUARANTY FUND CERTIFICATE:** Wanted to purchase-Guaranty Fund Certificates for the Illinois State Medical Inter Insurance Exchange—call (312) 423-4499.

**GUARANTY FUND CERTIFICATE** for sale: Class 5, territory II for $1,000,000/$1,000,000 coverage, purchase price $6,024.00. For sale for $4,500.00. For information call (816) 364-5255, or write to Professional Anesthesia Services, Inc., 416 North Seventh, St. Joseph, MO 64501.

**WANTED TO PURCHASE**—Guaranty Fund Certificate—Class VI—Illinois State Medical Inter-Insurance Exchange. Please contact Mrs. Yost—(312) 596-7070.

**I.S.M.S. GUARANTY FUND** ($6840.00) Certificate discounted for sale. Class 4, territory 1, number 7340, $1,000,000.00/$1,000,000.00. Sale price: $5130.00. Contact Sandra (312) 442-6500 Ex 233.

**$6,840.00 GUARANTY FUND CERTIFICATE** available at discount price through Surgeon's widow, Bonnie Kale, 312-246-1539 or Attorney, Paul Gerbosi, 346-7B00.

**ILLINOIS STATE MEDICAL INTER-INSURANCE EXCHANGE** Guaranty Fund Certificate for sale. Territory 1 Class 1. Purchase price $772. Best offer. Contact Dr. Moran at (312) 425-B000 Ext. 5566.

**WILL BUY** Guaranty Fund Certificate, Illinois State Medical Inter-Insurance Exchange, from retiring or departing physician. Contact Mrs. Yost (312) 596-7070.

**FOR SALE:** I.S.M.I.E. Guaranty Fund Certificate. Risk Class 5. Contact Glenn Drumheller (312) 947-4410 or (206) 259-1515, after 11/15/7B. Will discount 20%.

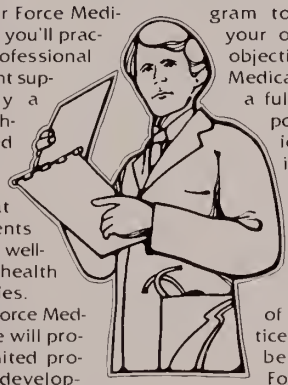
**GUARANTY FUND CERTIFICATE** for sale. Class II. 1 million/1 million coverage. At discount. Call (312) 484-5660.

**GUARANTY FUND CERTIFICATE:** Price (original) $6024.00, class 5 (now class 8), Plastic Surgery, territory II, 1,000,000/1,000,000 coverage. Have changed Insurance companies. Call J. Monasterio, M.D. 858-8396 or evenings at 858-8395.

**GUARANTY FUND CERTIFICATE,** Class 3, original cost of $3060, negotiable. Contact J. B. Pinski, M.D., 55 E. Washington, Chicago, IL 60602. (312) 263-4625.

*IMJ and ISMS are not acting as brokers or agents; this is provided as a membership service.*


# Physicians: we treat you seriously in the Air Force



As an Air Force Medical Officer, you'll practice in a professional environment supported by a team of highly qualified technical assistants. You'll treat your patients in modern, well-equipped health care facilities.

The Air Force Medical Service will provide unlimited professional development, with a carefully designed individual program to complement your own skills and objectives. Air Force Medical Centers offer a full range of opportunities in clinical medicine, including clinical investigation.

Avoid the time consuming burdens of private practice. Consider the benefits of Air Force medicine. Health care at its very best.

Capt. Stephen Dewoody
Air Force Recruiting Squadron
12th and Spruce Streets
St. Louis, Missouri 63102
Call Collect: 314-268-2471/2238

Air Force. A great way of life.



report

Illinois Society
American Association of Medical Assistants

## *Cook County Regional Meeting*

# "THE UNDETECTED DISEASE"

John Kelly is a 22-year-old male who lives at home with his family. His mother has called the office on many occasions to confide in the medical assistant about her son. She wants an appointment for John because something just isn't right, but she can't put her finger on it. She says he's lost weight and hasn't any desire to eat. There are many changes in his personality and she just doesn't seem to know her son anymore. Many appointments have been made for John, for all of which he has been a no-show. When follow-up calls were made to the patient regarding this, his personality revealed hostilty. Several months later the patient comes to the office and can't understand why he needs to be seen by a doctor. His attitude is very negative and despondent.

John Kelly is a fictitious person. He was developed to help illustrate characteristics of potential drug or alcohol abusers. Have you had a John Kelly in your medical office? What signs do you look for in a patient that could lead you to believe he or she could be a possible drug or alcohol abuser? When this person is identified, what types of help are available? How many good referrals are you aware of? What kind of encouragement are you able to extend? Is counseling available for the family as well?

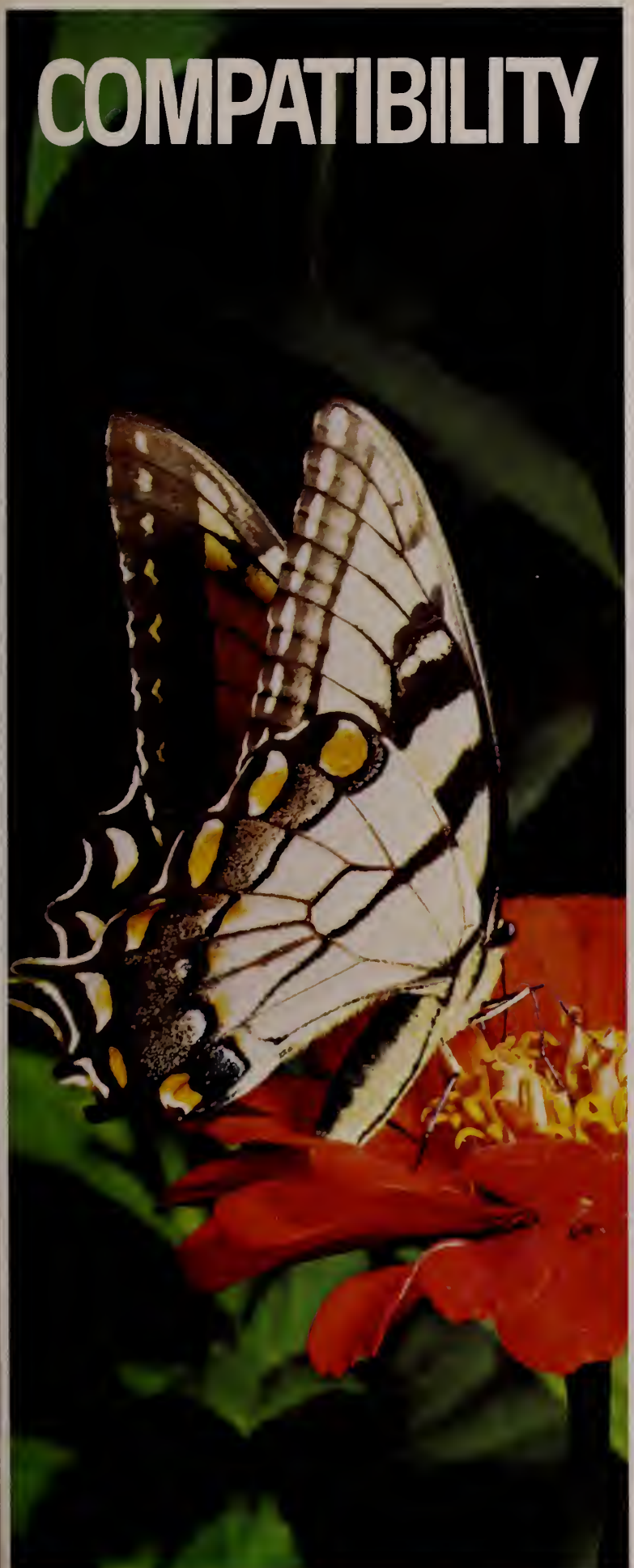
On Sunday, November 19, 1978, an all day meeting will be held at the Civic Center, 1420 Miner Street, in Des Plaines. The main objective of this gathering will be early detection and referral for drug and alcohol abusers.

Robert O'Neill is the Safety Education Officer at the Des Plaines Police Department. He will be presenting the drug problems in the community and how to deal with them in our youths. He will be giving information on street names of drugs, showing what they look like and how they are used. A film will be shown entitled, "Dead is Dead."

Ronald Melka is a Youth Advocate from Youth in Crisis. He has his B.A. in Psychology and Sociology. He also has been a volunteer trainer in drug crisis management for 2 years. He will be dealing with the types of counseling and referrals.

Mr. F. remains anonymous. He is a member of Alcoholics Anonymous. His presentation will be of his life experience and emotional aspects of the disease. He will show us the correct way to ask a case history and he will be showing a film endorsed by Bell Telephone called "Guidelines."

Registration after November 1, 1978, is $4.00 for AAMA members and $6.00 for non-members. The program is free to students. This knowledge will be a benefit for you in or out of the medical office. For a printed brochure or more information call or write Program Coordinator Cheryl Hurley, 312/960-4239, 547 Brookside Drive, Westmont, IL 60559, or Registration Chairman Mary Bouzoukis, 28 King Arthur Ct., Northlake, IL 60164.




# Does it influence your choice of a peripheral/cerebral vasodilator*?

- Vasodilan—compatible with coexisting diseases
- Vasodilan—compatible with concomitant therapy
- Vasodilan—compatible with your total regimen for vascular insufficiency

*__Indications:__ Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows:

Possibly Effective:

1. For the relief of symptoms associated with cerebral vascular insufficiency
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.

Final classification of the less-than-effective indications requires further investigation.

**Composition:** Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg.

Vasodilan injection, isoxsuprine HCl, 5 mg., per ml.

**Dosage and Administration:** Oral: 10 to 20 mg., three or four times daily.

Intramuscular: 5 to 10 mg. (1 or 2 ml.) two or three times daily. Intramuscular administration may be used initially in severe or acute conditions.

**Contraindications and Cautions:** There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

Parenteral administration is not recommended in the presence of hypotension or tachycardia.

Intravenous administration should not be given because of increased likelihood of side effects.

**Adverse Reactions:** On rare occasions oral administration of the drug has been associated in time with the occurrence of hypotension, tachycardia, nausea, vomiting, dizziness, abdominal distress, and severe rash. If rash appears the drug should be discontinued.

Although available evidence suggests a temporal association of these reactions with isoxsuprine, a causal relationship can be neither confirmed nor refuted.

Administration of single dose of 10 mg. intramuscularly may result in hypotension and tachycardia. These symptoms are more pronounced in higher doses. For these reasons single intramuscular doses exceeding 10 mg. are not recommended. Repeated administration of 5 to 10 mg. intramuscularly at suitable intervals may be employed.

**Supplied:** Tablets, 10 mg., bottles of 100, 1000, 5000 and Unit Dose; Tablets, 20 mg., bottles of 100, 500, 1000, 5000 and Unit Dose; Injection, 10 mg. per 2 ml. ampul, box of six 2 ml. ampuls.

U.S. Pat. No. 3,056,836

# VASODILAN®

## (ISOXSUPRINE HCl)

**20-mg tablets**

Mead Johnson PHARMACEUTICAL DIVISION

© 1978 MEAD JOHNSON & COMPANY • EVANSVILLE, INDIANA 47721 U.S.A. MJL7-4268

# This asthmatic isn't worried about his next breath...



## he's active
## he's effectively maintained on

# QUIBRON®

Each capsule or tablespoon (15 ml) elixir contains theophylline (anhydrous) 150 mg and glyceryl guaiacolate (guaifenesin) 90 mg. Elixir: alcohol 15%

- theophylline for effective around-the-clock bronchodilator therapy
- 100% free theophylline

**Indications:** For the symptomatic relief of bronchospastic conditions such as bronchial asthma, chronic bronchitis, and pulmonary emphysema.

**Warnings:** Do not administer more frequently than every 6 hours, or within 12 hours after rectal dose of any preparation containing theophylline or aminophylline. Do not give other compounds containing xanthine derivatives concurrently.

**Precautions:** Use with caution in patients with cardiac disease, hepatic or renal impairment. Concurrent administration with certain antibiotics, i.e. clindamycin, erythromycin, troleandomycin, may result in higher serum levels of theophylline. Plasma prothrombin and factor V may increase, but any clinical effect is likely to be small. Metabolites of guaifenesin may contribute to increased urinary 5-hydroxyindoleacetic acid readings, when determined with nitrosonaphtol reagent. Safe use in pregnancy has not been established. Use in case of pregnancy only when clearly needed.

**Adverse Reactions:** Theophylline may exert some stimulating effect on the central nervous system. Its administration may cause local irritation of the gastric mucosa, with possible gastric discomfort, nausea, and vomiting. The frequency of adverse reactions is related to the serum theophylline level and is not usually a problem at serum theophylline levels below 20 $\mu$g/ml.

**How Supplied:** Capsules in bottles of 100 and 1000 and unit-dose packs of 100; Elixir in bottles of 1 pint and 1 gallon.

See package insert for complete prescribing information.

**Mead Johnson** PHARMACEUTICAL DIVISION

©1978 Mead Johnson & Company • Evansville, Indiana 47721 U.S.A. MJL 8-4294R




# Resident Physicians Comprise 36% of New ISMS Members

By Linda L. Hughey, M.D./Wilmette

*This is a monthly column which welcomes contributions, comments, and questions from interested readers. Address all correspondence to Dr. Linda Hughey, c/o the Illinois Medical Journal, 55 E. Monroe, Chicago, Ill. 60603.*

Since January 1, 1978, 221 of 621 new ISMS members have been residents. Thus 36% of all new ISMS members since the first of the year have been resident members. Illinois, with 1,051 resident AMA members, ranked second only to New York State (2,204 resident AMA members) in 1977.

The membership success in Illinois can be attributed to two things: a supportive state medical society structure and an active Resident Physician Section. The Illinois State Medical Society grants residents a reduced dues as well as resident seats on the major councils. The state society offers residents many benefits from group insurance, seminars, and publications. The ISMS Resident Physician Section is a recognized group with bylaws and a budget based upon Resident membership in the state society.

Building a strong base of young physicians knowledgeable about State Society structure and concerns can only benefit the state medical societies. In California the state society has gone so far as to recognize the residents as a separate "county" from the standpoint of representation at medical society functions. While Illinois has chosen to have residents affiliated via their local chapters, we as residents must realize nonetheless that the ISMS offers a great deal of support to resident members. And the residents have responded by supporting the ISMS with new memberships.

## DOCUMENTATION AT LAST RESIDENTS ARE INDEED COST-EFFECTIVE

Hartford Hospital hired an independent auditing firm to determine the hospital cost of maintaining services without educational programs. In other words, did residents and nursing students provide services which were worth more to the hospital than the total cost of the educational programs involved in their training programs? It should come as no surprise to most residents that the auditing firm found residents and other trainees more than pulled their weight: the operating budget would have to be increased to provide similar services in the absence of residents. Even after granting generous allowances for residents being "less efficient' than staff physicians (which a study in *Journal of the American Hospital Association* grants is a questionable assumption) the cost of hiring physicians to perform resident functions outstripped the costs of resident education.

This information is hardly surprising to residents who are able to add together the amount their hospitals can bill patients for the services rendered by residents. But the Hartford study (*JAHA* 47: 65-74, March 1, 1973) by Drs. Freymann and Springer, might be useful to residents negotiating contracts. Residents may be considered "students" but they pull their own weight in keeping their hospitals solvent.

## AMA RESIDENT PHYSICIANS SECTION INTERIM MEETING

The AMA-RPS Interim Business Meeting will be held December 1-2 in Chicago. The meeting will include workshops and speakers of general interest, social gatherings as well as the RPS Interim Business Meeting. Details and a schedule of events can be obtained from the AMA Department of Housestaff Affairs, 535 N. Dearborn St., Chicago 60610 or 312-751-6000.



# Illinois State Medical Inter-Insurance Exchange

## The physician-owned professional liability insurance program

- Occurrence Coverage
- Choice of Limits
- Quarterly Premium Payments
- Part-Time Coverage Available

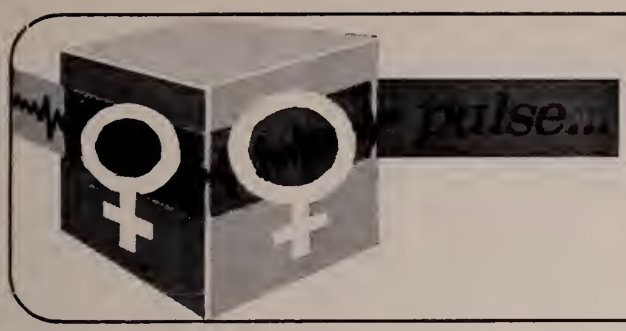
A physician-oriented, reciprocal insurance program for ISMS members



*Administered by*

Illinois State Medical Insurance Services, Inc.

55 East Monroe Street, Chicago, Illinois 60603 • 312/782-1654




# of the ISMS auxiliary

Mrs. Eugene Vickery, Editor



Mrs. Earl V. Klaren, President, ISMSA

## *Growth Patterns*

# News From Around the Counties

### Adams County Auxiliary Approaches 40 Years of Community Service

Since 1939, when the Adams County Medical Society Auxiliary was founded, its members have been involved in a wide variety of community service projects. In 1942, ACMSA was featured in Life Magazine for assistance given the American Red Cross blood donor program. Since that time, members have been responsible for nurse recruitment programs, a Homemaker Health Aide Service, World Medical Relief Programs and many AMA-ERF projects. Last year, ACMSA concentrated on immunization programs, painting the "Immunization Hopscotch" on school playgrounds.

This year's project in Adams County is a two-pronged attack on child health issues: scoliosis screening and nutrition education in the schools.

### Public Health and Safety Projects Reported from Morgan-Scott County

The Morgan-Scott Medical Society Auxiliary was formed in October of 1964. In the ensuing years, their numbers grew from three to thirty-two active auxilians, who can boast many projects of enduring importance.

Morgan-Scott efforts have included a number of educational campaigns focused on lay persons confronted with medical emergencies, pamphlets giving access information to emergency services, and distributions of water safety materials. Other efforts have included projects for AMA-ERF, distributions of posters describing the a maneuver to prevent food choking, and fund-raising for HOPE and the ISMS Benevolence fund.

Last Year, Morgan Scott initiated their first International Dinner, an effort to extend friend-

ship to new physicians' wives, particularly those from foreign countries. Members plan to continue the dinners as a special tradition, and are enthused about prospects for another year of community education and service.

**Stephenson County Gains National Recognition**

A telephone book listing of health care and social services compiled by members of the Stephenson County Medical Auxiliary was recently lauded by the Department of Health, Education and Welfare as a "novel concept in human services."

In 1975, SCMA compiled a full-page listing of contact access numbers for persons in Stephenson County. The list touched upon such needs as ambulance services, organizations for handicapped persons, sources of freely loaned medical equipment, and mental health adjunct groups. That listing has been published in the local telephone book each year, undoubtedly resolving countless crises.

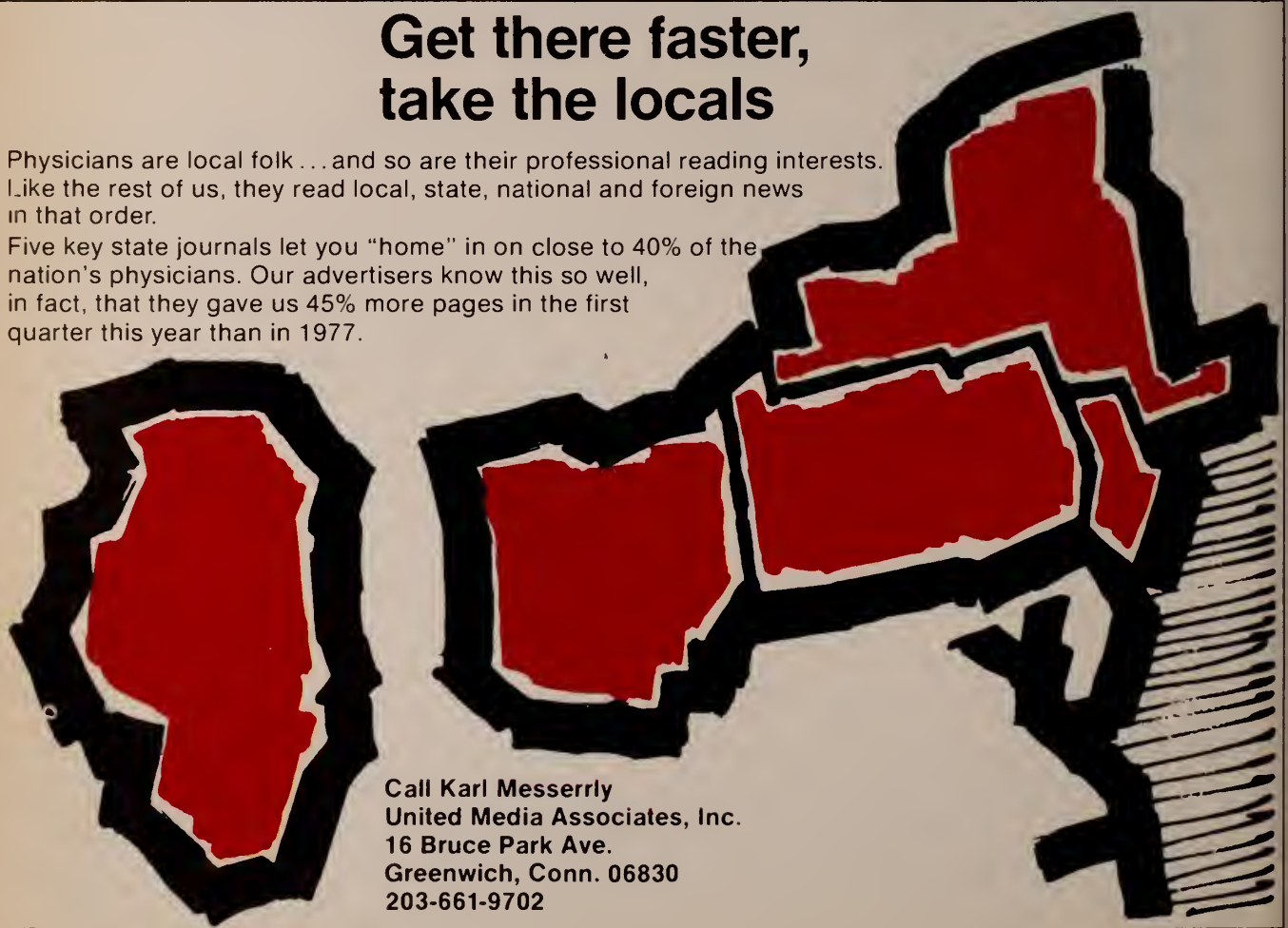


Stephenson County's projects received special attention at state convention this year, when they were given the annual Achievement Award. Pictured above, 1977-78 President Esther Lopez proudly displays their plaque.


# Get there faster, take the locals

Physicians are local folk . . . and so are their professional reading interests. Like the rest of us, they read local, state, national and foreign news in that order.

Five key state journals let you "home" in on close to 40% of the nation's physicians. Our advertisers know this so well, in fact, that they gave us 45% more pages in the first quarter this year than in 1977.



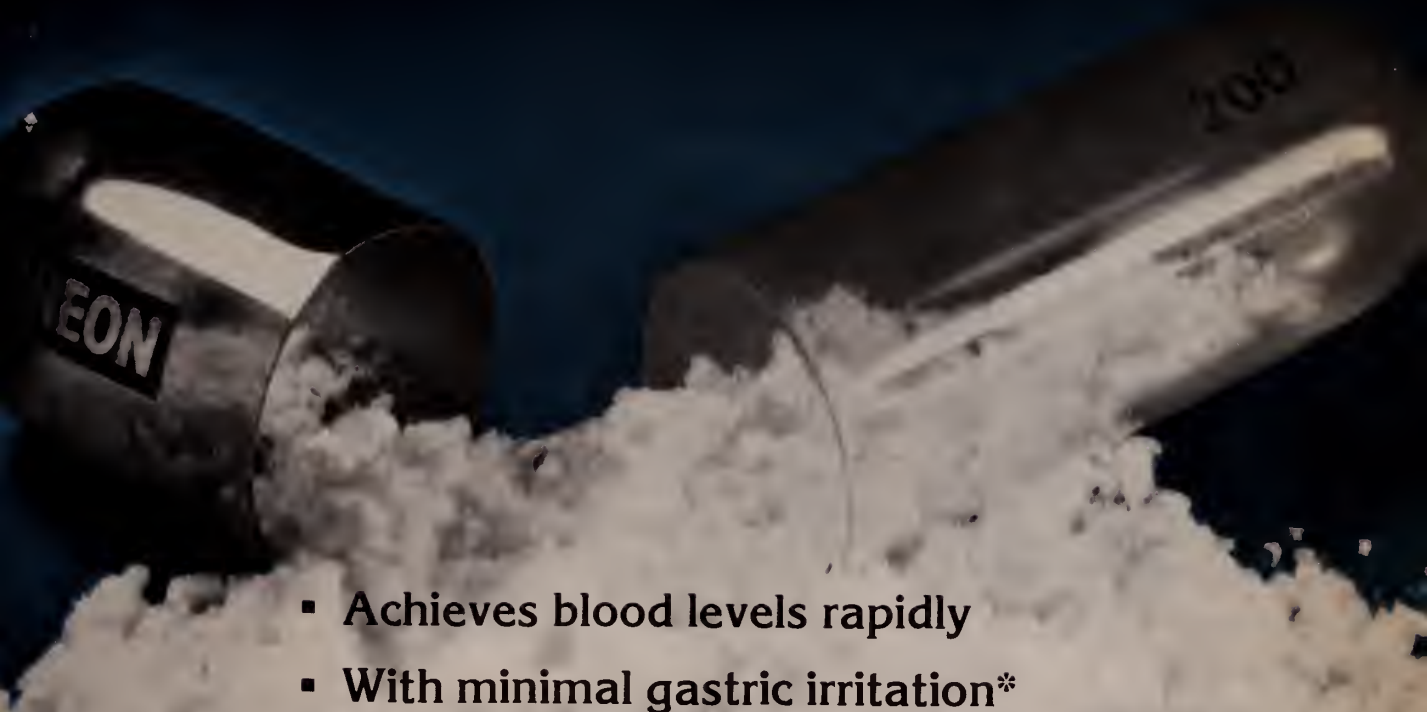
**Call Karl Messerrly**
**United Media Associates, Inc.**
**16 Bruce Park Ave.**
**Greenwich, Conn. 06830**
**203-661-9702**

# A Difference in Theophylline Therapy

## micro-pulverized

# BRONKODYL® Capsules

brand of theophylline, USP (anhydrous)




- Achieves blood levels rapidly
- With minimal gastric irritation*

*Please see complete prescribing information, a summary of which follows.

**DESCRIPTION:**
Each green and white hard gelatin capsule contains theophylline USP anhydrous, 200 mg., in a micro-pulverized form. Each brown and white hard gelatin capsule contains 100 mg. The elixir contains 80 mg. theophylline per 15 ml. in a 20% alcohol elixir (approximately 20 calories, 0.9 gm carbohydrate per tablespoontul).

**ACTION:** Theophylline is a methylxanthine which relaxes the smooth musculature of the bronchioles through its inhibition of the conversion of cyclic adenosine monophosphate to adenosine monophosphate by phosphodiesterase. It also has diuretic, cardiotonic, and CNS stimulant effects.

**INDICATIONS:** Bronkodyl is indicated for symptomatic relaxation of bronchiotar spasm in the chronic obstructive bronchopulmonary diseases; e.g., bronchial asthma, chronic bronchitis and pulmonary emphysema.

**CONTRAINDICATIONS:** Bronkodyt is contraindicated in persons known to have had serious idiosyncratic responses to theophylline, its salts, or the other methylxanthines, theobromine, or caffeine and may be contraindicated in peptic ulcer.

**WARNINGS:** All methylxanthines should be used with caution in children and in others who are currently taking bronchodilator products, especially in rectal dosage form, which may contain theophylline or related drugs.

**USAGE IN PREGNANCY:** Although theophylline has been used for many years, with no evidence of adverse fetal effect or teratogenicity, its safety in pregnancy has not been established. Therefore use of Bronkodyl during lactation or in women of childbearing potential requires that possible benefits of the drug be weighed against possible hazards to fetus or child.

**PRECAUTIONS:** Bronkodyl should be used with caution in patients with cardiac or circulatory disease.

**ADVERSE REACTIONS:** Gastrointestinal: Epigastric distress, nausea, vomiting. Cardiovascular: palpitations. CNS: Insomnia, restlessness, irritability, convulsion.

**DOSAGE AND ADMINISTRATION:** Adults: Usual dosage of Bronkodyl is 200 mg. every 6 hours (four doses in each 24 hours). This dosage may be adjusted to reflect individual clinical response as an indication of slow or rapid metabolism of the drug. If adverse reactions are encountered, each dose may be reduced, or the interval between doses may be lengthened, or both. If clinical response is not satisfactory, indicating possible rapid inactivation of the drug, dosage may be gradually increased to achieve the desired response. In some instances of either too slow or too rapid metabolism, plasma levels of theophylline should be determined and dosage adjusted accordingly to achieve levels above 10 mcg/ml, but not to exceed 20 mcg/ml.

Dosage in Children: Usual dosage should be based on administration of 10 mg per kg per 24 hours, divided in 4 doses per day, given every 6 hours. As this may not be possible with use of the capsules, Bronkodyt elixir may be used. Theophylline saliva levels (approximately 60% of simultaneous blood levels), may facilitate dosage adjustments, especially in children, to obtain appropriate response.

**HOW SUPPLIED:**
Bronkodyt 100 mg., brown and white capsules in 100's, Code #1831.
Bronkodyt 200 mg., green and white capsules in 100's, Code #1833.
Bronkodyl Elixir, 80 mg. per 15 ml, in pints, Code #1835.

BREON LABORATORIES INC.
90 Park Avenue, New York, N.Y. 10016

# EKG

*(Continued from page 336)*

**Answers:** **1. A. B.** **2. E.**

A careful examination of the rhythm strip at rest shows a short PR interval of 0.10 seconds and a small delta wave. This man had the ECG of the Wolff-Parkinson-White syndrome. The ST segment starts to depress at six minutes of exercise and is depressed more than one millimeter with an upsloping ST segment contour at eleven minutes. This is an abnormal ST segment in exercise. However, Wolff-Parkinson-White syndrome is a well known cause of false-positive exercise tests. In the case of the Wolff-Parkinson-White syndrome, ST segment depression does not suggest ischemic heart disease. As further support for this, the ECG strip marked recovery (REC), shows an alternating Wolff-Parkinson-White syndrome. Note that the beats with a delta wave and a short PR interval have a depressed ST segment while the beats with a normal PR interval of 0.14 seconds have normal ST segments. In this strip, the heart rate is regular at 96 beats per minute. This could also be interpreted at 2:1 Kent bundle block since the delta wave only appears in every other beat. No premature beats were seen. None of the management choices are indicated. An age adjusted maximal target heart rate for this 45 year old man would be 175 beats per minute. His maximal heart rate of 130 beats per minute is only 74% of the target heart rate although he exercised over eleven minutes. He was allowed to begin a walking and jogging program to a maximal heart rate of approximately 105 beats per minute and 20 to 30 minute sessions for the first month.

# INDEX TO ADVERTISERS


## Pharmaceuticals

| | |
|---|---|
| **385** | **Breon Laboratories**<br>*Bronkodyl* |
| **Cover 2** | **Burroughs Wellcome Co.**<br>*Empirin Compound w/Codeine* |
| **337** | **Eli Lilly and Co.**<br>*Keflex* |
| **379-380** | **Mead Johnson Pharmaceutical Div'n.**<br>*Vasodilan*<br>*Quibron* |
| **331** | **Roche Laboratories**<br>**Div. of Hoffman-LaRoche**<br>*Librium* |
| **Covers 3-4** | **Roche Laboratories**<br>**Div. of Hoffman-LaRoche**<br>*Valium* |
| **334-335** | **Schering Corporation**<br>*Optimine* |
| **333** | **Smith Kline and French Labs.**<br>**Div. of SmithKline Corp.**<br>*Isocult* |
| **342** | **Upjohn Pharmaceuticals**<br>*Tolinase* |

## Insurance

| | |
|---|---|
| **382** | **Illinois State Medical**<br>**Inter-Insurance Exchange**<br>*Professional Liability Insurance* |
| **363** | **Medical Protective Co.**<br>*Professional Liability Insurance* |
| **347** | **Parker Aleshire and Co.**<br>*Group Insurance* |

## Services and Continuing Education

| | |
|---|---|
| **360** | **AVIS**<br>*Auto Rentals* |
| **341** | **Bio-Science Laboratories** |
| **339-340** | **Blue Cross/Blue Shield Report** |
| **351** | **Cook County Graduate School**<br>*Continuing Medical Education* |
| **372** | **IMPAC** |
| **368** | **Oak Forest Hospital**<br>*Position Opportunity* |
| **384** | **United Media Associates** |
| **377** | **U.S. Air Force**<br>*Recruitment* |


*Our advertisers serve the Medical Profession and support your Journal. All advertisers are approved by your Journal Committee. It will help you and your society to mention your Journal when writing them.*

*Space Representatives:* United Media Associates, Inc., 16 Bruce Park Avenue, Greenwich, Conn. 06830

# When the somatic symptoms are there but the signs of organic disease are not

## it could be the message of psychic tension

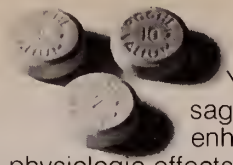


## for prompt, dependable relief of psychic tension and its somatic symptoms

# VALIUM® (IV)

## (diazepam)

2-mg, 5-mg, 10-mg scored tablets



You've often seen the message of psychic tension: anxiety-enhanced CNS activity, resulting in physiologic effects that produce the somatic symptoms the patient complains about. Although your workup reveals no organic cause, the patient may still be convinced that he has a serious disease.

For many patients, functional disorders are both difficult to understand and to accept. How do you treat the condition? With the necessary supportive measures, including counseling and reassurance. And often, Valium (diazepam) can be one of your strongest therapeutic allies.

Valium works promptly and dependably to reduce excessive psychic tension. Often, your patient feels calmer within hours and within days response is both pronounced and sustained. Equally important, Valium is usually well tolerated. Side effects more serious than drowsiness, fatigue and ataxia are rare. Of course, as with all CNS-acting agents, patients on Valium should be cautioned against drinking alcohol or operating dangerous machinery. Periodic reassessment of therapy with Valium is also recommended.

**Before prescribing, please consult complete product information, a summary of which follows:**

**Indications:** Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders; athetosis; stiff-man syndrome; convulsive disorders (not for sole therapy).

The effectiveness of Valium (diazepam) in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.

**Contraindicated:** Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

**Warnings:** Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

***Usage in Pregnancy:*** **Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

**Precautions:** If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

**Side Effects:** Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

**Dosage:** Individualize for maximum beneficial effect. *Adults:* Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients:* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children:* 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

**Supplied:** Valium® (diazepam) Tablets, 2 mg, 5 mg and 10 mg—bottles of 100 and 500; Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10; Prescription Paks of 50, available singly and in trays of 10.

ROCHE

Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

# THE MESSAGE OF TENSION...




**To relieve psychic tension and its functional symptoms**

# VALIUM® (diazepam)

2-mg, 5-mg, 10-mg scored tablets

ROCHE

# Illinois Medical Journal

OFFICIAL JOURNAL OF THE
ILLINOIS STATE MEDICAL SOCIETY

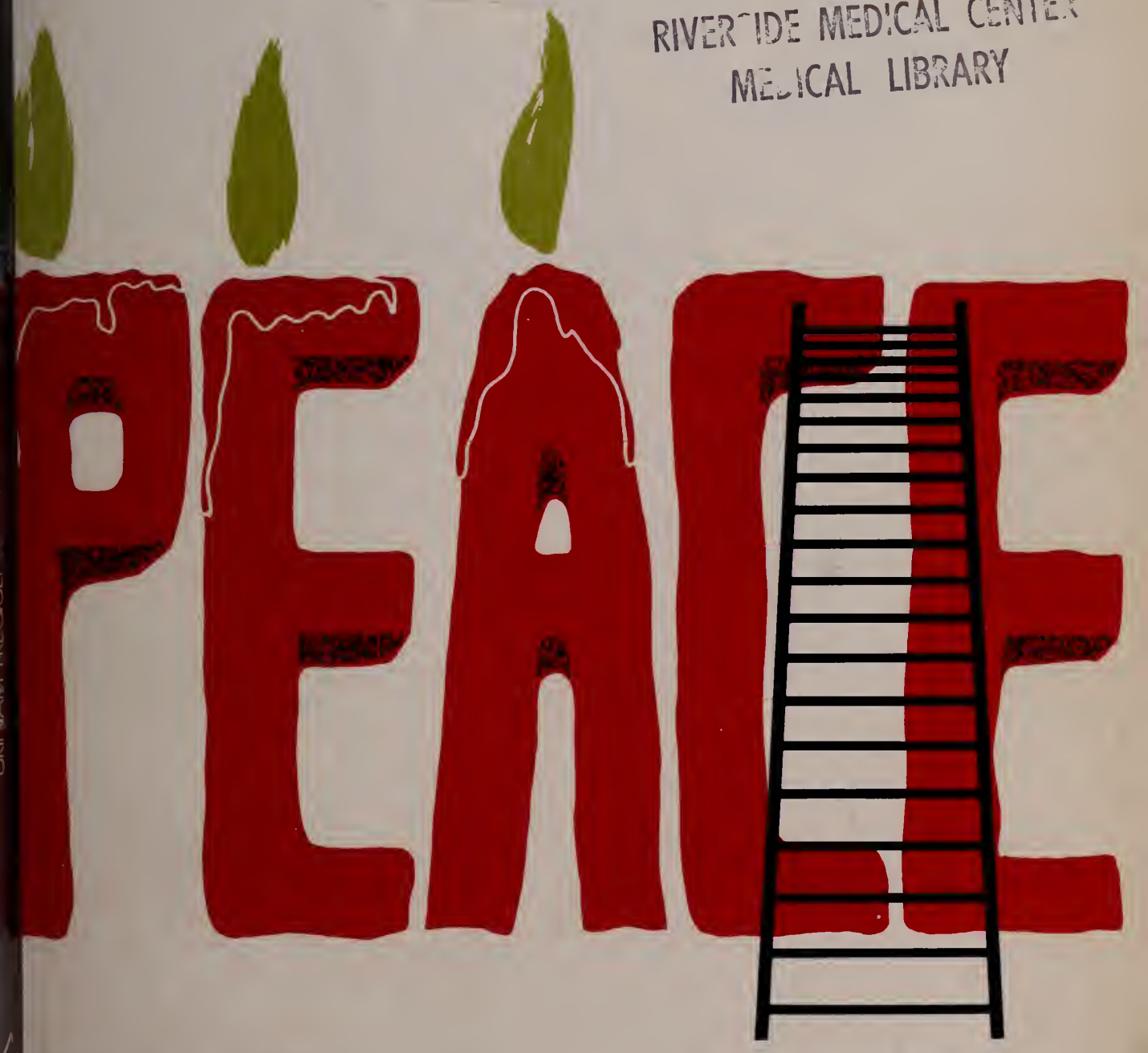
154, NO. 6/DECEMBER 1978



CHIEF OF MEDICAL STAFF
RIVERSIDE HOSP.
350 N. WALL ST. BOX 749
KANKAKEE, IL 60901

BALCONY

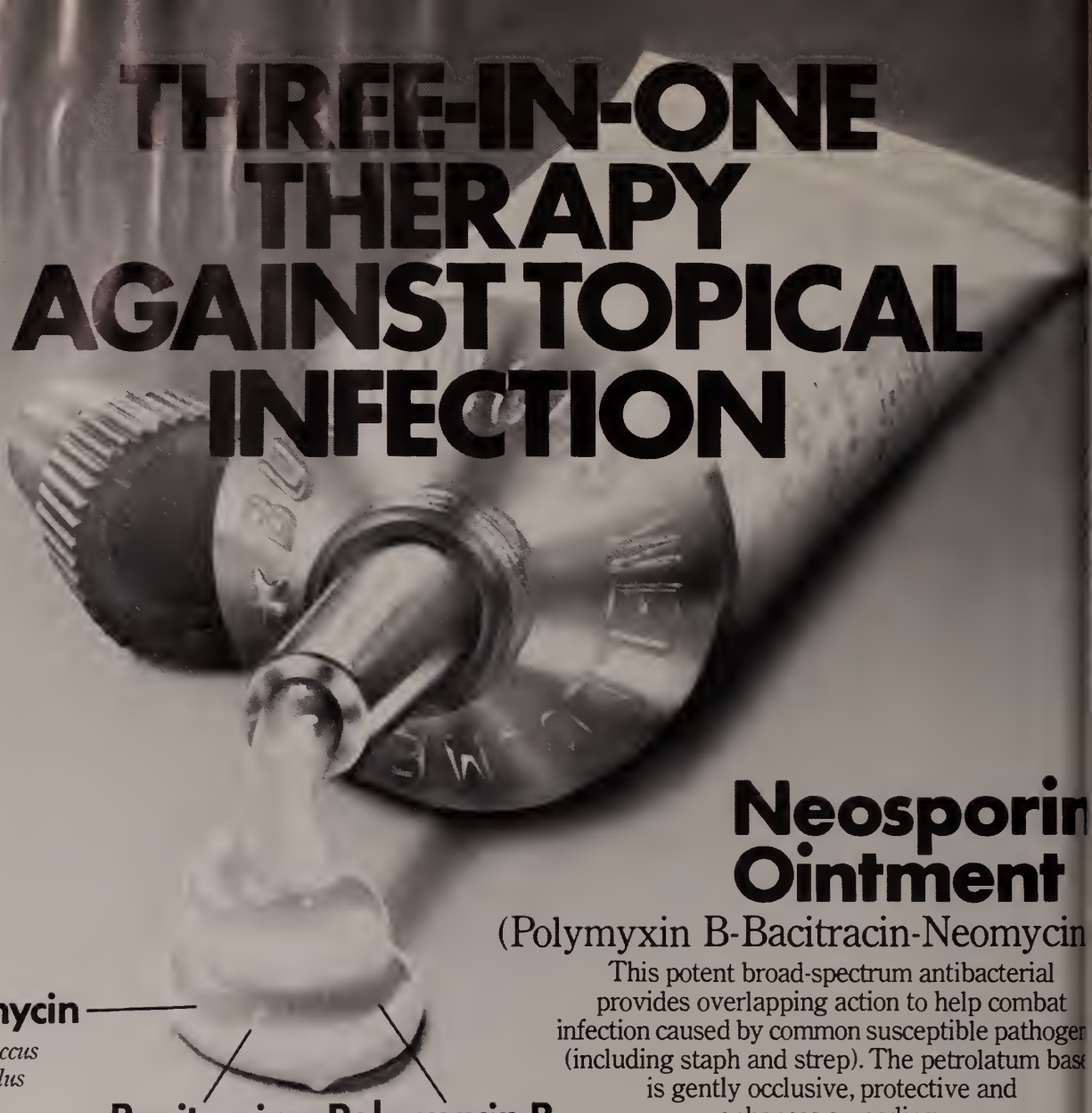
RIVERSIDE MEDICAL CENTER
MEDICAL LIBRARY



NVENTION SUMMARY ... 413
ESIDENT'S PAGE ..... 447
BLE OF CONTENTS ..... 387

# THREE-IN-ONE THERAPY AGAINST TOPICAL INFECTION



## Neosporin Ointment

(Polymyxin B-Bacitracin-Neomycin

This potent broad-spectrum antibacterial provides overlapping action to help combat infection caused by common susceptible pathoger (including staph and strep). The petrolatum bas is gently occlusive, protective and enhances spreading.

**Neomycin**

*Staphylococcus*
*Haemophilus*
*Klebsiella*
*Aerobacter*
*Escherichia*
*Proteus*
*Corynebacterium*
*Streptococcus*
*Pneumococcus*

**Bacitracin**

*Staphylococcus*
*Corynebacterium*
*Streptococcus*
*Pneumococcus*

**Polymyxin B**

*Pseudomonas*
*Haemophilus*
*Klebsiella*
*Aerobacter*
*Escherichia*

*In vitro* overlapping antibacterial action of Neosporin® Ointment (polymyxin B-bacitracin-neomycin).

Wellcome

**Burroughs Wellcome C**
Research Triangle Par
North Carolina 27709

---

## Neosporin® Ointment

(Polymyxin B-Bacitracin-Neomycin)

Each gram contains: Aerosporin® brand Polymyxin B Sulfate 5,000 units; zinc bacitracin 400 units; neomycin sulfate 5 mg (equivalent to 3.5 mg neomycin base); special white petrolatum qs; in tubes of 1 oz and 1/2 oz and 1/32 oz (approx.) foil packets.

**WARNING:** Because of the potential hazard of nephrotoxicity and ototoxicity due to neomycin, care should be exercised when using this product in treating extensive burns, trophic ulceration and other extensive conditions where absorption of neomycin is possible. In burns where more than 20 percent of the body surface is affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended.

When using neomycin-containing products to control secondary infection in the chronic dermatoses, it should be borne in mind that the skin is more liable to become sensitized to many substances, including neomycin. The manifestation of sensitization to neomycin is usually a low grade reddening with swelling, dry scaling and itching; it may be manifest simply as failure to heal. During long-term use of neomycin-containing products, periodic examination for such signs is advisable and the patient should be told to discontinue the product if they are observed. These symptoms regress quickly on withdrawing the medication. Neomycin-containing applications should be avoided for that patient thereafter.

**PRECAUTIONS:** As with other antibacterial preparation prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measur should be taken if this occurs.

**ADVERSE REACTIONS:** Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section).

Complete literature available on request from Professional Services Dept. PML.

IMJ

Illinois Medical Journal

DECEMBER, 1978 Vol. 154, No. 6 CONTENTS

431 Accumulative Index, Volume 154

392 Abstracts of Board of Trustees Actions

*Clinical Articles*

405 Scrotal Hernia Associated with Carcinoma of the Colon
*By Harry L. Miller, M.D., Smiljan Puljic, M.D., and Harry Gordimer, M.D.*

*Case Reports*

407 Spontaneous Pneumopericardium
*By Charles L. Lansford, M.D., and Jack C. Cooley, M.D.*

409 High Altitude Pulmonary Edema
*By Thomas S. Kim, M.D.*

*Convention Summary*

413 Summary of House of Delegates Actions

418 Actions on Resolutions

*President's Page*

447 Speak Up
*David S. Fox, M.D.*

*(Contents continued on overleaf)*

## *Features*


389 Clinics for Crippled Children
391 Viewbox
399 EKG
402 Obituaries
412 Illinois Society, American Association of Medical Assistants
428 Housestaff News
437 ISMS Guide to Continuing Medical Education
442 Physician Recruitment
445 Doctor's News
451 Classified Advertising


## *Staff*


**Managing Editor** . . . . . **Richard A. Ott**
**Assistant Editor** . . . . . **Mariann M. Stephens**
**Executive Administrator** . . . . . **Roger N. White**

*(Cover by Alene Goren-Taylor)*

### PUBLICATIONS COMMITTEE

Herschel Browns, M.D., Chicago, *Chairman*
Kenneth A. Hurst, M.D., Naperville
Robert P. Johnson, M.D., Springfield
Alfred J. Kiessel, M.D., Decatur
Harold J. Lasky, M.D., Chicago

### Editorial Board

J. William Roddick, Jr., M.D., Springfield, *Chairman*
Eli L. Borkon, M.D., Carbondale
Daniel R. Cunningham, M.D., Wilmette
Raymond A. Dieter, Jr., M.D., Glen Ellyn
James G. Ekeberg, M.D., Palatine
Ediz Z. Ezdinli, M.D., Kenilworth
Carl Neuhoff, M.D., Peoria
Constantine S. Soter, M.D., Arlington Heights
Donald D. VanFossan, M.D., Springfield

Contributor in Surgery: John M. Beal, M.D., Chicago
Contributor in Maternal Death Studies:
Robert R. Hartman, M.D., Jacksonville
Contributor in Pediatric Perplexities: Ruth Andrea Seeler, M.D., Chicago
Contributor in Radiology: Leon Love, M.D., Maywood
Contributor in Cardiology: John R. Tobin, M.D., Maywood
Contributor in Immunopathology: Richard J. Ablin, Ph.D., Chicago
Contributor in Rheumatology: L. F. Layfer, M.D., Chicago


## ILLINOIS STATE MEDICAL SOCIETY


### OFFICERS

David S. Fox, M.D., President
826 E. 61st St., Chicago 60637
P. John Seward, M.D., President-Elect
310 N. Wyman St., Rockford 61101
Herschel Browns, M.D., 1st Vice-President
4600 N. Ravenswood, Chicago 60640
G. W. Giebelhausen, M.D., 2nd Vice-President
1101 Main St., Peoria 61606
Audley F. Connor, Jr., M.D., Secretary-Treasurer
7531 S. Stony Island Ave., Chicago 60649

### HOUSE OF DELEGATES

Cyril C. Wiggishoff, M.D., Speaker
25 E. Washington, Chicago 60602
Robert P. Johnson, M.D., Vice-Speaker
108 Maple Grove, Springfield 62707

### TRUSTEES

1st District: 1980, John J. Ring, M.D.
511 Hawley, Mundelein 60060
2nd District: 1980, Allan L. Goslin, M.D.
712 N. Bloomington, Streator 61364
3rd District: 1979, Alfred Clementi, M.D.
675 W. Central Rd., Arlington Heights 60005
3rd District: 1980, Raymond J. Des Rosiers, M.D.
1044 N. Francisco, Chicago 60622
3rd District: 1979, Robert T. Fox, M.D.
2136 Robincrest, Glenview 60025
3rd District, 1979, Jere Freidheim, M.D.
3050 S. Wallace, Chicago 60616
3rd District: 1981, Morris T. Friedell, M.D.
7531 S. Stony Island Ave., Chicago 60649
3rd District: 1981, Henrietta Herbolsheimer, M.D.
1700 E. 56th St., Chicago 60637
3rd District: 1981, Lawrence L. Hirsch, M.D.
2434 Grace St., Chicago 60618
3rd District: 1980, Harold J. Lasky, M.D.
55 E. Washington, Chicago 60602
3rd District: 1980, Richard N. Rovner, M.D.
645 N. Michigan, Suite 920, Chicago 60611
3rd District: 1980, Joseph C. Sherrick, M.D.
303 E. Superior, Chicago 60611
4th District: 1979, Fred Z. White, M.D.
723 N. Second St., Chillicothe 61523
5th District: 1979, P. F. Mahon, M.D.
800 E. Carpenter, Springfield 62702
6th District: 1981, Robert R. Hartman, M.D.
1515 A. W. Walnut, Jacksonville 62650
7th District: 1979, Alfred J. Kiessel, M.D.
1 Powers Lane Pl., Decatur 62522
8th District: 1979, James Laidlaw, M.D.
104 W. Clark, Champaign 61820
9th District: 1981, Warren D. Tuttle, M.D.
203 N. Vine St., Harrisburg 62946
10th District: 1981, Julian W. Buser, M.D.
6600 W. Main St., Belleville 62223
11th District: 1980, Kenneth A. Hurst, M.D.
52 Bunting Lane, Naperville 60540
12th District: 1980, Joseph Perez, M.D.
5670 E. State St., Rockford 61108
Trustee-At-Large: George T. Wilkins, M.D.
27 Glen Echo Dr., Edwardsville 62025
Chairman of the Board: Robert R. Hartman, M.D.
1515 A. W. Walnut, Jacksonville 62650



Microfilm copies of current as well as some back issues of the *Illinois Medical Journal* may be purchased from Xerox University Microfilm, 300 North Zeeb Road, Ann Arbor, Mich. 48106.

Contents of *IMJ* are listed in the *Current Contents/Clinical Practice.*

Published by the Illinois State Medical Society, 55 E. Monroe St., Chicago, Ill. 60603 (312-782-1654)



Copyright, 1978. The Illinois State Medical Society. All material subject to this copyright may be photocopied for the noncommercial purpose of scientific or educational advancement.



Subscription $12.00 per year, in advance, postage prepaid, for the United States, Cuba, Puerto Rico, Philippine Islands and Mexico. $15.00 per year for all foreign countries included in the Universal Postal Union. Canada $12.50. U.S. Single current copies available at $1.00 ($1.10 by mail), back issues $1.50.

Second class postage paid at Chicago, Ill. When moving please notify Journal office of new address including old mailing label with notification, if possible. POSTMASTER: Send notice on form No. 3579 to Illinois State Medical Society, 55 E. Monroe St., Chicago, Ill. 60603.

Pharmaceutical advertising must be approved by the ISMS Publications Committee. Other advertising accepted after review by Publications Committee or Board of Trustees. All copy or plates must reach the Journal office by the fifteenth of the month preceding publication. Rates furnished upon request.

Original articles will be considered for publication with the understanding that they are contributed only to the *Illinois Medical Journal.* The ISMS denies responsibility for opinions and statements expressed by authors or in excerpts, other than editorial or allied views or statements which reflect the authoritative action of the ISMS or of reports on official actions, policies or positions. Views expressed by authors do not necessarily represent those of the Society; any connection with official policies is coincidental.

The *Illinois Medical Journal* is published by the Illinois State Medical Society as an educational and professional informational magazine and distributed as a benefit of membership in the Illinois State Medical Society. Its intent is to keep members current in medical knowledge and is a part of a continuing medical education program. Socioeconomic matters, affecting as they do a changing pattern in the proper delivery of medical care, are considered an inherent element in medical education.

# Clinics for Crippled Children Listed for January

Thirty-four clinics for Illinois' physically handicapped children have been scheduled for January by the University of Illinois, Division of Services for Crippled Children. The clinics provide diagnostic orthopedic, pediatric, speech and hearing examination, along with medical, social and nursing services. There will be special clinics for children with cardiac conditions and children with cerebral palsy. Any private physician may refer to or bring to a convenient clinic any child or children for whom he may want examination or consultative services.

January 2 Park Ridge Cardiac—Lutheran General Hospital
January 3 Hinsdale—Hinsdale Sanitarium
January 4 Effingham—St. Anthony Memorial Hospital
January 4 Lake County Cardiac—Victory Memorial Hospital
January 5 Division Cardiac—U. of I. at the Medical Center
January 8 Peoria Cardiac—St. Francis Hospital
January 9 East St. Louis—Christian Welfare Hospital
January 9 Quincy—Blessing Hospital
January 10 Champaign-Urbana—McKinley Hospital
January 10 Chicago Heights General—St. James Hospital
January 10 Joliet Clinic—St. Joseph's Hospital
January 10 Cairo—Public Health Department
January 11 Springfield—St. John's Hospital
January 11 Macomb—McDonough District Hospital
January 12 Chicago Heights Cardiac—St. James Hospital
January 15 Maywood—Loyola Medical Center
January 16 Belleville—St. Elizabeth's Hospital
January 16 Decatur—Decatur Memorial Hospital
January 16 Rock Island—Moline Public Hospital
January 17 Springfield P.N.—St. John's Hospital
January 17 Centralia—St. Mary's Hospital
January 17 Evergreen Park—Little Company of Mary Hospital
January 18 Elmhurst Cardiac—Memorial Hospital of Dupage County
January 18 Rockford—Rockford Memorial Hospital
January 19 Kankakee Cardiac—St. Mary's Hospital
January 22 Peoria Cardiac—St. Francis Hospital
January 24 Chicago Heights General—St. James Hospital
January 24 Elgin—Sherman Hospital
January 24 Mt. Vernon—Good Samaritan Hospital
January 26 Chicago Heights Cardiac—St. James Hospital
January 30 Alton—Alton Memorial Hospital

The Division of Services for Crippled Children is the official state agency established to provide medical, surgical, corrective and other services and facilities for diagnosis, hospitalization and after-care for children with crippling conditions or who are suffering from conditions that may lead to crippling. In carrying on its program, the Division works cooperatively with local medical societies, hospitals, the Illinois Children's Hospital-School, civic and fraternal clubs, visiting nurse associations, local social and welfare agencies, local chapters of the National Foundation and other interested groups. In all cases, the work of the Division is intended to extend and supplement, not supplant, activities of other agencies, either public or private, state or local, carried on in behalf of crippled children.




# Librax®

Each capsule contains 5 mg chlordiazepoxide HCl and 2.5 mg clidinium Br.

**Please consult complete prescribing information, a summary of which follows:**

**Indications:** Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

"Possibly" effective: as adjunctive therapy in the treatment of peptic ulcer and in the treatment of the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.

Final classification of the less-than-effective indications requires further investigation.

**Contraindications:** Glaucoma; prostatic hypertrophy, benign bladder neck obstruction; hypersensitivity to chlordiazepoxide HCl and/or clidinium Br.

**Warnings:** Caution patients about possible combined effects with alcohol and other CNS depressants, and against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Physical and psychological dependence rarely reported on recommended doses, but use caution in administering Librium® (chlordiazepoxide HCl) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions) reported following discontinuation of the drug.

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy. Advise patients to discuss therapy if they intend to or do become pregnant.**

As with all anticholinergics, inhibition of lactation may occur.

**Precautions:** In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patients receiving the drug and oral anticoagulants, causal relationship not established.

**Adverse Reactions:** No side effects or manifestations not seen with either compound alone reported with Librax. When chlordiazepoxide HCl is used alone, drowsiness, ataxia, confusion may occur, especially in elderly and debilitated; avoidable in most cases by proper dosage adjustment, but also occasionally observed at lower dosage ranges. Syncope reported in a few instances. Also encountered: isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent, generally controlled with dosage reduction; changes in EEG patterns may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice, hepatic dysfunction reported occasionally with chlordiazepoxide HCl, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax typical of anticholinergic agents, *i.e.*, dryness of mouth, blurring of vision, urinary hesitancy, constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.

ROCHE

Roche Products Inc.
Manati, Puerto Rico 00701



## In treating certain G.I. disorders...

# Enhance your therapeutic expectations with the triple benefits of

## Adjunctive

# Librax®

Each capsule contains
5 mg chlordiazepoxide HCl
and 2.5 mg clidinium Br

## antianxiety/antisecretory/antispasmodic

Librax is unique among G.I. medications in providing the specific antianxiety action of LIBRIUM® (chlordiazepoxide HCl) as well as the potent antisecretory and antispasmodic actions of QUARZAN® (clidinium Br) for adjunctive therapy of irritable bowel syndrome* and duodenal ulcer.*

ROCHE

Librax has been evaluated as possibly effective for this indication.
Please see brief summary of prescribing information on preceding page.



# the viewbox

LEON LOVE, M.D./CHAIRMAN/DEPARTMENT OF RADIOLOGY
LOYOLA UNIVERSITY STRITCH SCHOOL OF MEDICINE

*This month's VIEWBOX was submitted by Robert E. Henkin, M.D., Associate Professor of Radiology, Director of Nuclear Medicine, Loyola University Medical Center, Maywood, Illinois.*

*This 31-year-old white male has recently been experiencing shortness of breath. His chest X-ray and representative images from a gallium-67 citrate scan are provided.*



**Figure 1**



**Figure 2**



**Figure 3**

## *What's your diagnosis?*

1. Carcinoma of the lung
2. Malignant lymphoma
3. Viral pneumonitis
4. Sarcoidosis

*(Continued on page 449)*

# *Abstracts of Board Actions*

**November 3-4, 1978** **Rockton**

*These abstracts are published so that members of the Illinois State Medical Society may keep advised of the actions of the Board of Trustees. It covers only major actions and is not intended as a detailed report. Full minutes of the meetings are available upon any member's request to the headquarters office of the ISMS.*

## Legal Action

ISMS will file an amicus curiae brief in a case involving confidentiality of hospital staff committee records. The brief—aimed at protecting the immunity statute which ISMS fought to enact—will be filed during appeal of a lower court ruling which held that testimony presented to in-hospital staff committees is confidential and inadmissable in court and the person providing the testimony is immune from civil liability.

In actions involving malpractice litigation, the Board voted to:

- Explore options available to assist in an appeal of the highly-publicized malpractice countersuit of Dr. Leonard Berlin. An appellate court recently reversed Dr. Berlin's lower court victory on the grounds that Dr. Berlin did not state a cause of action. The suit is based upon the theory that lawyers have a duty to those they sue and the general public as well as their clients. It was the first time in the nation that a trial court accepted the argument. The case could "break new legal ground" in countersuits. Dr. Berlin will petition the Illinois Supreme Court and possibly the U.S. Supreme Court to review the case on constitutional grounds.
- File an amicus curiae brief and provide support and technical assistance if a physician's countersuit—based upon malicious prosecution—is appealed. The brief would focus on Illinois case law which now requires that special damages be proved in order to sustain a charge of malicious prosecution.
- File an amicus curiae brief in an appeal of a lower court decision that would challenge the respondent in discovery rule. ISMS will focus on abuse of the rule and also question its constitutionality. Under the rule, the respondent, in some respects, is treated as a defendant—although not named in the suit—and there is considerable risk that his constitutional rights may not be protected.

## AMA Dues Billing

ISMS will meet with AMA representatives to seek an increase in the dues remittance paid to state societies for shared distribution with those county societies who do their own dues collection. Last June, the Board endorsed the AMA Criteria for Dues Billing and Remittance—outlining a rebate formula tied to early submission of dues—which qualified ISMS for a new reimbursement rate which it planned to share on a 50-50 basis with component societies involved in the billing and collection process. However, reports indicate that the proposed rate is insufficient to attract submission of early dues.

## Legislation

During the upcoming General Assembly session, ISMS will seek legislation dealing with these aspects of malpractice litigation:

- *Statute of Limitations:* Prohibit the filing of a suit more than two years after the date of the alleged act, except that a minor under the age of six would have until his eighth birthday to file.

*(Continued on page 424)*

Blue Cross®
Blue Shield®

# REPORT FOR *Illinois Physicians*

## Health Care Achievement Awards Given At Symposium

Nine Health Care Achievement Awards for outstanding accomplishments in the private health sector were presented by Blue Cross and Blue Shield at its third annual symposium, "Private Initiatives in Health Care," held November 15, 1978 at Hyatt Regency in Chicago. The symposium, which also featured nationally prominent speakers, attracted over 650 guests.

Honored were health care providers, physicians, businesses and associations that have made significant progress in the areas of cost containment, quality and accessibility. The awards program was inaugurated by Blue Cross and Blue Shield to call attention to exceptional achievements in these critical areas.

Award winners in the Physicians' category were Drs. George T. Mitchell and Eugene P. Johnson. The two physicians were instrumental in development of two comprehensive medical centers in Clark County. The program was implemented at a time when the area was faced with a loss of doctors and a lack of adequate health services. The Cork and Casey Medical Centers were opened in conjunction with two extended care facilities. The centers, where the two physicians serve as solo practitioners, attracted new doctors, nurses, dentists and other professionals to Clark County.

Other winners were:

PREPAID GROUP PRACTICE—Abraham Lincoln HMO. The downstate HMO in Lincoln became fully operational in 1974 and now serves 1,614 members in Logan County. The HMO offers an extensive benefit program stressing outpatient and preventive care services with an estimated savings of $175,000 for its members. The HMO has attracted new physicians to the central Illinois area.

GROUP PRACTICE—Occupational Health Services. OHS of Rockford is a joint venture of health care providers that offers professional, physical and emotional care to northern Illinois employers. Employers utilize OHS as a central source of comprehensive services for employees. The program is designed to help employers maintain a healthful work environment; facilitate placement of employees; provide care and rehabilitation of occupationally ill and acutely injured employees; and assist in providing measures for personal care.

TEACHING HOSPITALS — Illinois Masonic Medical Center. The center was cited for development of an alternative birthing center in it labor and delivery/postpartum department.

LARGE COMMUNITY HOSPITALS—St. Francis Xavier Cabrini Hospital. The hospital was honored for its city doctor program which was launched when the facility faced a dwindling physician population, declining admissions and mounting deficits. Fourteen physicians were provided with offices and, in return, they referred in-patients to Cabrini. The result has been improved health care for area residents and an increase in the hospital's occupancy rate from 63 to 82 percent.

SMALL COMMUNITY HOSPITALS — Perry Memorial Hospital. The hospital dealt with the excess bed issue by achieving a 40% reduction to 105 beds in 1976. In addition, it helped develop an ambulatory care facility.

BUSINESSES—United States Steel Corporation Steel Works. U.S. Steel South Works was cited for establishment of a counseling center to provide confidential, personalized, professional services free of charge to any employee or member of their family.

ASSOCIATIONS—Illinois Health Improvement Association. The HIA was cited for its scholarship and medical student loan fund. The downstate organization has made loans and scholarships totaling $120,000 in the last five years.

ASSOCIATIONS—River Bend Ambulance Association. The ambulance association was honored for dealing with a lack of adequate mobile emergency care in the Fulton-Albany area. The nonprofit group raised $11,000 locally and received a grant to launch a new ambulance service. It now has 16 members and provides service that is no more than five minutes away from any emergency situation in the area.

# INFORMATION ON MEDICARE PART B

## Coverage of Hydrophilic Soft Contact Lenses

Reimbursement may be made under the prosthetic device benefit for the following hydrophilic soft contact lenses when prescribed on or after the dates shown for the aphakic patient:

| Lens | Manufacturer | Effective Date |
|---|---|---|
| Softlens (polymacon) | Bausch & Lomb, Inc. | March 18, 1971 |
| Hydrocurve (hefilcon A) | Soft Lenses, Inc. | April 30, 1974 |
| Naturvue | Milton Roy, Inc. | May 5, 1976 |
| Tresoft | Alcon Laboratories, Inc. | Feb. 18, 1977 |
| Tri Pol 43 (deltafilcon A) | G and S Lens Company | April 27, 1978 |
| Softcon (vifilcon A) | Warner-Lambert Company (American Optical Corp. | June 30, 1978 |
| Amsof (deltafilcon A) | Lombart Lenses, Ltd. | June 30, 1978 |

Hydrophilic soft contact lenses are not covered when used in the treatment of nondiseased eyes with spherical ametrophea, refractive astigmatism, and/or corneal astigmatism. Lenses can only be covered when used as a prosthetic device.

### Coverage of Hydrophilic Soft Contact Lens for Corneal Bandage

When used as a moist bandage in the treatment of bullous keratopathy, payment may be made for either the Softcon (vifilcon A) corneal bandage lens produced by Warner-Lambert Company (effective with respect to services furnished on and after August 2, 1973) or for the soft contact lens produced by Bausch & Lomb, Inc. (effective with respect to services furnished on and after March 13, 1975). To be covered as a supply incident to a physician's service, the lens must have been applied and removed by the physician billing for the lens.

## Changes in Participation and Certification of Laboratory Procedures

Notices were received from the Medicare Bureau of the following changes in approved tests and procedures of laboratories in the Medicare program:

Holleb Laboratory, Inc., 924 Waukegan Road, Glenview, Illinois 60025 (Provider Number 14-8114) has been approved to perform Procedure 110-Bacteriology, effective August 25, 1978. The laboratory had previously been approved to perform Procedures 200-Serology; 310 Chemistry Routine; 320-Clinical Microscopy; 400-Hematology; 710-EKG Services.

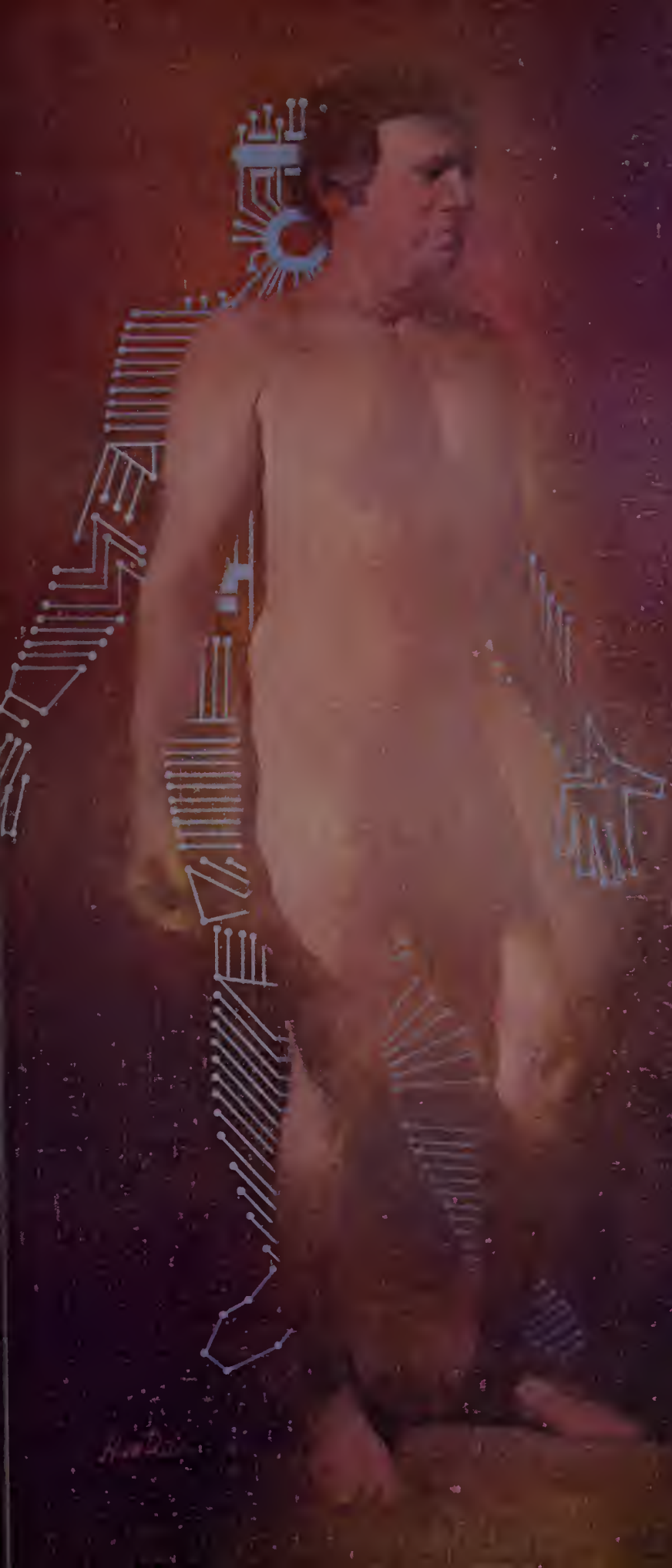
Garco Medical Laboratory, 935 W. Belmont Ave., Chicago, Illinois 60657 (Provider Number 14-8221) is no longer performing Digoxin testing under Procedure 330-Chemistry Other. Effective deletion date is December 1, 1978. The laboratory is approved to perform Procedures 110-Bacteriology; 130-Parasitology; 200-Serology; 310-Chemistry Routine; 320-Clinical Microscopy; 510-Blood Group and Rh Typing; 630-Diagnostic Cytology; 710 EKG Services; 400-Hematology.

Alpha Medical Laboratories, 7110 West 127th Street, Palos Heights, Illinois (Provider Number 14-8222) has been approved for the following procedures effective August 17, 1978; 300-Chemistry; 510-Blood Group and Rh Typing; 520-Rh Titers; 610-Tissue Pathology; 630-Diagnostic Cytology. It had previously been approved for Procedures 110-Bacteriology; 200-Serology; 400-Hematology; and 710-EKG Services.

Ace Diagnostic Laboratory, 1411 W. Irving Park Road, Chicago, Illinois 60613 (Provider Number 14-8293) has been approved to perform Procedure 710-EKG Services, effective June 7, 1978. The laboratory had previously been approved to perform Procedures 110-Bacteriology; 200-Serology; 310-Chemistry Routine; 320-Clinical Microscopy; 510-Blood Group and Rh Typing; 630-Diagnostic Cytology.

Lius Medical Laboratory, Inc., 1429 W. Irving Park Road, Chicago, Illinois 60613 (Provider Number 14-8320) has been approved to perform Procedure 400-Hematology, effective September 6, 1978. It had been approved to perform Procedures 110-Bacteriology; 200-Serology; 630-Diagnostic Cytology; 310-Routine Chemistry and 320-Clinical Microscopy.

South Suburban Medical Laboratory, 2800 W. 87th Street, Chicago, Illinois 60652 (Provider Number 14-8176) is no longer approved to perform Procedure 630-Diagnostic Cytology. Effective deletion date is December 1, 1978. The laboratory is approved to perform Procedures 310-Chemistry Routine and 320-Clinical Microscopy.



# 20 days to shape his world

Your diagnosis is firm: Primary Hypertension.*

His future is in your hands now. The next 20 days are decisive.

What are the odds against that future? The sad fact is, half of America's hypertensives drop out of treatment.[1]

*You can improve those odds.* We can help you. Here's how:

**1.** COUNSEL: Talk to your patient about the disease and its consequences—about the problem of strokes, heart attacks, and kidney failure. Emphasize the need for taking the medication you've chosen, daily, and for the rest of your patient's life. Teach your patient about the drugs you prescribe—their effects and side effects. The more he knows, the more he'll be involved.

**2.** CATAPRES® (clonidine hydrochloride): because the data show that people stay with it. It has a high adherence rate.[2] There are good and substantial reasons why patients stay with Catapres—read them on the next pages.

Counsel...and Catapres. They can help change the odds against your patient's future. And to change them even more, ask us for these from your Boehringer representative:

—A major new film on Methods of Compliance
—A useful and extensive monograph on compliance
—The Onesti paper
—Patient Aid Booklet
—Patient worksheets
—Patient Reminder Postcards
—Other effective compliance enhancers

*By repeated determinations of the basal blood pressure,** and once the medical history, physical examination, including funduscopic and routine laboratory tests,† have been completed, one is usually able to exclude secondary causes and to be reasonably comfortable with a diagnosis of primary or essential hypertension.

**The National Hypertension Program Study Committee, in September, 1972, recommended blood pressures exceeding 140/90 mm Hg be regarded as excessive for adult Americans under age 50. The World Health Committee ceiling has been 160/95 mm Hg.

†Hematocrit, urinalysis, creatinine (or urea nitrogen), triglycerides, cholesterol, uric acid, plasma glucose, serum potassium, electrocardiogram, and chest x-ray.

Please see brief summary of prescribing information on last page of advertisement for warnings, precautions, and adverse reactions.






Tablets of 0.1 and 0.2 mg

# Catapres® (clonidine HCl) can help you shape his world

For most hypertensives, you need only two drugs... a diuretic and Catapres.

Start with either, depending on your judgment.

## If you've come to expect only this much of Catapres...

1. smooth lowering of blood pressure
2. effective for all degrees of hypertension (mild to moderate in potency)
3. brain, heart, and kidney blood flow preserved

## Ask for more of Catapres®

1. no contraindications
2. low incidence of depression and orthostatic hypotension
3. normal hemodynamics
4. no fatal hepatotoxicity
5. excellent record of compliance

**Most common side effects are dry mouth, drowsiness, and sedation, which generally tend to diminish with time.**

Please see brief summary of prescribing information on last page of advertisement for warnings, precautions, and adverse reactions.

Tablets of 0.1 and 0.2 mg

# Catapres®
# (clonidine HCl)

**It gives you more than you expect of Catapres**




Tablets of 0.1 and 0.2 mg

# Catapres® (clonidine HCl) can help you shape his world

Counsel...and Catapres. They can help change the odds against your patient's future. And to change them even more, ask us for these from your Boehringer representative:

—A major new film on Methods of Compliance
—A useful and extensive monograph on compliance
—The Onesti paper
—Patient Aid Booklet
—Patient worksheets
—Patient Reminder Postcards
—Other effective compliance enhancers

**References:**
1. Wilber JA, Barrow JS: Am J Med, 52:653-663, 1972.
2. Data on file at Boehringer Ingelheim Ltd.

Boehringer Ingelheim

Boehringer Ingelheim Ltd
Ridgefield, CT 06877

**Catapres® brand of clonidine hydrochloride**
Tablets of 0.1 mg and 0.2 mg

**Indication:** The drug is indicated in the treatment of hypertension. As an antihypertensive drug, Catapres (clonidine hydrochloride) is mild to moderate in potency. It may be employed in a general treatment program with a diuretic and/or other antihypertensive agents as needed for proper patient response.

**Warnings:** Tolerance may develop in some patients necessitating a reevaluation of therapy.
*Usage in Pregnancy:* In view of embryotoxic findings in animals, and since information on possible adverse effects in pregnant women is limited to uncontrolled clinical data, the drug is not recommended in women who are or may become pregnant unless the potential benefits outweigh the potential risk to mother and fetus.
*Usage in Children:* No clinical experience is available with the use of Catapres (clonidine hydrochloride) in children.

**Precautions:** When discontinuing Catapres (clonidine hydrochloride), reduce the dose gradually over 2 to 4 days to avoid a possible rapid rise in blood pressure and associated subjective symptoms such as nervousness, agitation, and headache. Patients should be instructed not to discontinue therapy without consulting their physician. Rare instances of hypertensive encephalopathy and death have been recorded after cessation of clonidine hydrochloride therapy. A causal relationship has not been established in these cases. It has been demonstrated that an excessive rise in blood pressure, should it occur, can be reversed by resumption of clonidine hydrochloride therapy or by intravenous phentolamine. Patients who engage in potentially hazardous activities, such as operating machinery or driving, should be advised of the sedative effect. This drug may enhance the CNS-depressive effects of alcohol, barbiturates and other sedatives. Like any other agent lowering blood pressure, clonidine hydrochloride should be used with caution in patients with severe coronary insufficiency, recent myocardial infarction, cerebrovascular disease or chronic renal failure.

As an integral part of their overall long-term care, patients treated with Catapres (clonidine hydrochloride) should receive periodic eye examinations. While, except for some dryness of the eyes, no drug-related abnormal ophthalmologic findings have been recorded with Catapres (clonidine hydrochloride), in several studies the drug produced a dose-dependent increase in the incidence and severity of spontaneously occurring retinal degeneration in albino rats treated for 6 months or longer.

**Adverse Reactions:** The most common reactions are dry mouth, drowsiness and sedation. Constipation, dizziness, headache, and fatigue have been reported. Generally these effects tend to diminish with continued therapy. The following reactions have been associated with the drug, some of them rarely. (In some instances an exact causal relationship has not been established.) These include: Anorexia, malaise, nausea, vomiting, parotid pain, mild transient abnormalities in liver function tests; one report of possible drug-induced hepatitis without icterus and hyperbilirubinemia in a patient receiving clonidine hydrochloride, chlorthalidone and papaverine hydrochloride. Weight gain, transient elevation of blood glucose, or serum creatine phosphokinase; congestive heart failure, Raynaud's phenomenon; vivid dreams or nightmares, insomnia, other behavioral changes, nervousness, restlessness, anxiety and mental depression. Also rash, angioneurotic edema, hives, urticaria, thinning of the hair, pruritus not associated with a rash, impotence, urinary retention, increased sensitivity to alcohol, dryness, itching or burning of the eyes, dryness of the nasal mucosa, pallor, gynecomastia, weakly positive Coombs' test, asymptomatic electrocardiographic abnormalities manifested as Wenckebach period or ventricular trigeminy.

**Overdosage:** Profound hypotension, weakness, somnolence, diminished or absent reflexes and vomiting followed the accidental ingestion of Catapres (clonidine hydrochloride) by several children from 19 months to 5 years of age. Gastric lavage and administration of an analeptic and vasopressor led to complete recovery within 24 hours. Tolazoline in intravenous doses of 10 mg at 30-minute intervals usually abolishes all effects of Catapres (clonidine hydrochloride) overdosage.

**How Supplied:** Catapres, brand of clonidine hydrochloride, is available as 0.1 mg (tan) and 0.2 mg (orange) oval, single-scored tablets in bottles of 100 and 1000.

For complete details, please see full prescribing information.

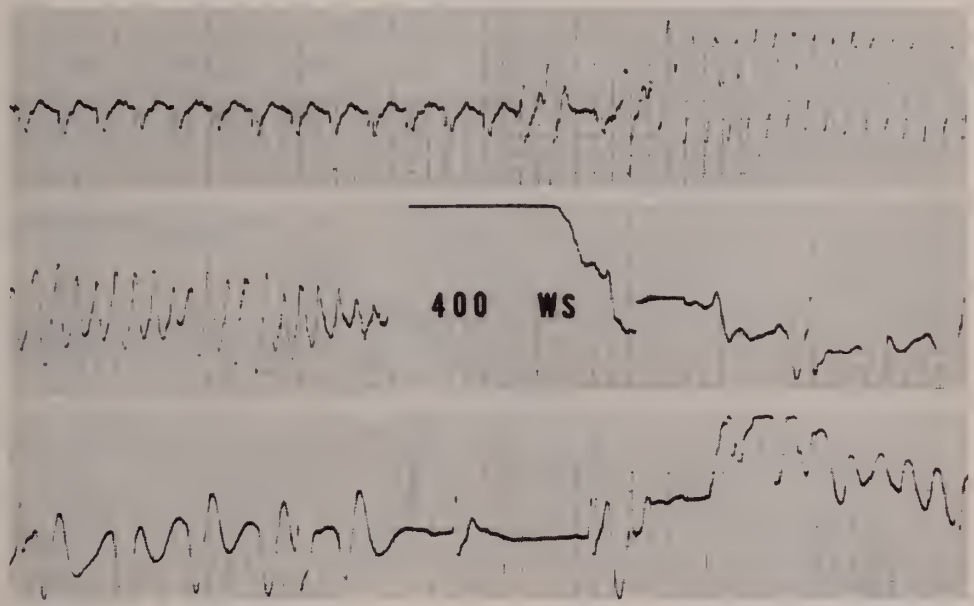
Under license from Boehringer Ingelheim GmbH

Distributed by
Boehringer Ingelheim Ltd.
Ridgefield, CT 06877

# ekg of the month

John F. Moran, M.S., M.D., David J. Hale, M.D.,
Patrick J. Scanlon, M.D., Sarah A. Johnson, M.D.,
John R. Tobin, M.S., M.D., and Rolf M. Gunnar, M.S., M.D.
Section of Cardiology, Department of Medicine,
Loyola University Stritch School of Medicine

*This patient is a fifty-one-year-old man who initially presented with incapacitating angina pectoris. He had a history of an uncomplicated myocardial infarction three years earlier. Coronary anteriography was recommended and demonstrated significant proximal three vessel disease with fair left ventricular function. Open heart surgery with three saphenous vein aortocornary bypass grafts was performed. His post-operative course was uneventful except for frequent premature ventricular beats, an occasional pair or couplet and short runs of ventricular tachycardia. He was given Procainamide in increasing doses until the ventricular irritability was eliminated. This was 500 milligrams of Procainamide every four hours. He did well and returned fourteen months later for a multistage exercise test by the method of Bruce. Unknown to his personal physician or the exercise lab physician was the fact that the patient had gradually reduced his Procainamide to the point where he had taken none at all for two months. He exercised on the treadmill for nine minutes and fifteen seconds when he collapsed. The rhythm strip shows the end of exercise and immediate recovery period.*




## *Questions:*

**1. The ECG rhythm strip shows:**

A. Normal ST segment response to exercise.
B. A pair of premature ventricular beats, or a couplet.
C. Deteriorating ventricular flutter.
D. A direct current cardioversion with a 400 watt-second (WS) shock.
E. All of the above.

**2. The following statement(s) are true:**

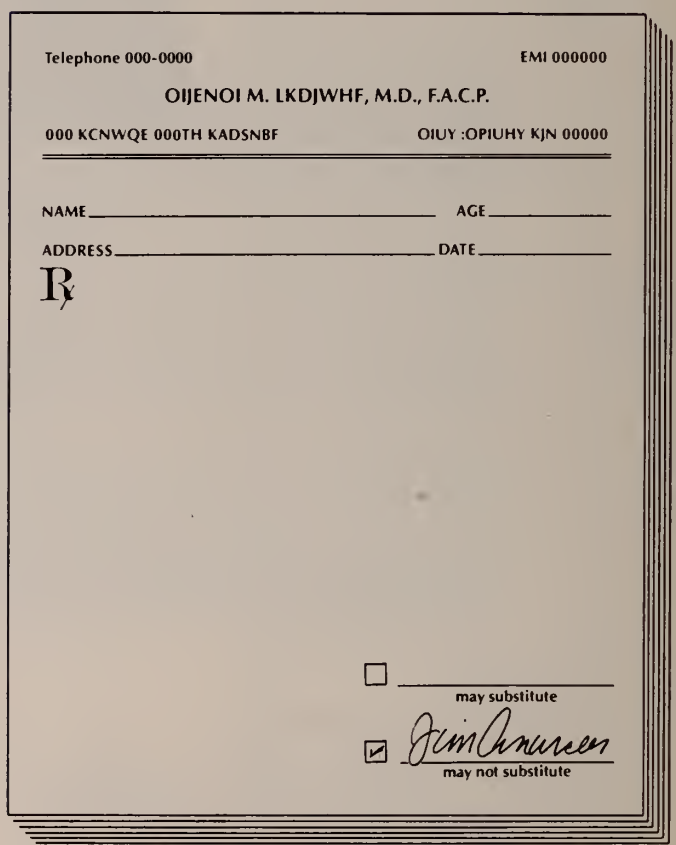
A. A large number of patients must discontinue Procainamide due to a variety of toxic manifestations of the drug.
B. Successful aorta coronary bypass surgery for severe proximal coronary artery disease does not routinely eliminate ventricular arrhythmias.
C. Multistage exercise testing is a safe procedure. The incidence of death on the treadmill in the Minnesota survey was less than one on 10,000 tests.
D. All of the above.

*(Continued on page 449)*

# Your rights are on the bottom line.

As a physician, you have the right to prescribe the drug which you believe will most benefit your patients. Now, a new Illinois state law makes it more difficult to exercise this right. Unless you sign your prescriptions on the bottom line of your new prescription pads, the pharmacist is permitted to substitute another drug for your brand-name prescription.

This means that the ultimate drug selection will no longer be yours; its source will be left to the pharmacist's discretion. You will have forfeited your right to prescribe as you see fit. Preserve your rights. Specify that you will accept no substitution.




© 1978. Pfizer Inc

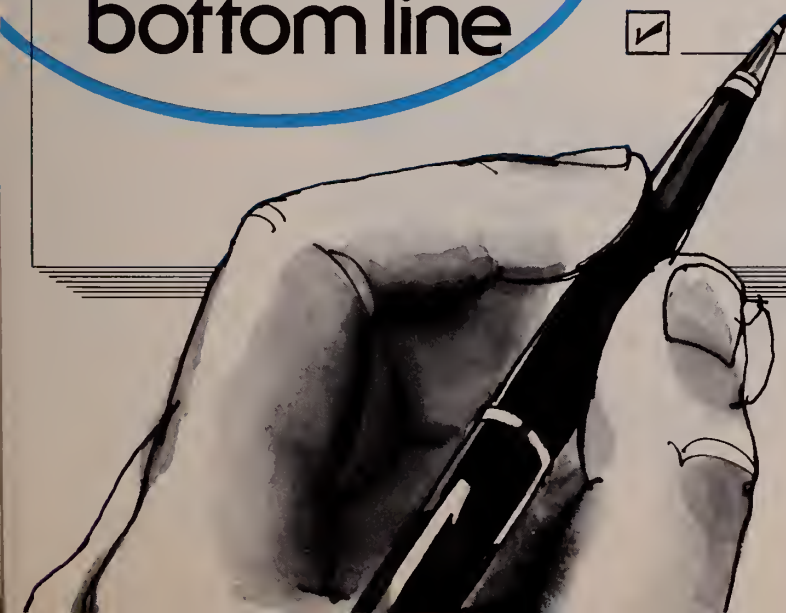
# When you sign on the bottom line...

- You ensure that your patient receives exactly that product you have specified on your prescription
- You choose the quality of the product dispensed to your patient
- You can be confident that your patient is given the identical drug with the same therapeutic equivalency when refills are authorized
- You can exercise the right to select a product based upon its proven therapeutic performance and to select a manufacturer that stands behind its brand name or generic product
- You can support the kinds of research programs that are vital to new drug discovery and development
- You can help sustain important physician, pharmacist and patient education services supported by innovative, research-oriented firms
- You preserve your right to practice medicine precisely as you see fit

## To preserve your rights, sign on the bottom line

☐ _____ may substitute

☑ Jim Andrews may not substitute



The complete text of the Illinois State Substitution Law and other helpful information is available from your local Pfizer Representative.

Pfizer PHARMACEUTICALS

# Obituaries

Breed, Thomas B., Palos Park, died in September, 1978.

°Burgert, Paul H., Lake Forest, died October 4, at the age of 68. He was a 1935 graduate of Northwestern University where he had also held the position of assistant professor. Dr. Burgert was president of the medical staff and chairman of the department of medicine at Lake Forest Hospital.

°Carney, John F., Joliet, died October 31, at the age of 60. Dr. Carney graduated from Northwestern University Medical School in 1943. He was a fellow of the College of Surgeons, affiliated with St. Joseph and Silver Cross Hospitals.

°Dailey, Paul E., Springfield, died November 18, at the age of 70. A 1937 graduate of the Chicago Medical School, Dr. Dailey practiced in Carrollton, and later served as consultant to the Federal Disability Program and IDPH in Springfield. He also served as Vice-President of ISMS and a member of the Illinois delegation to the AMA and the ISMS Committee on Nutrition. On the county level, Dr. Dailey held many different positions with the Sangamon and Green County Medical Societies. He also was a fellow of the American Academy of Family Practice.

Foley, Walter E., Davenport, died September 23, 1978.

Gordon, Alolphus Jr., Chicago, died September 20, 1978 at the age of 76. Dr. Gordon was a graduate of the Northwestern University School of Medicine. Prior to his death he was on the staff of Provident Hospital.

°°Heller, Samuel, Chicago, died July 17, at the age of 79. He was a 1924 graduate of the General Medical College. Dr. Heller was a staff member of Norwegian American Hospital.

Jensen, Joseph E., Laguna Hills, California, died August 26, 1978 at the age of 81. Dr. Jensen was a 1924 graduate of Rush Medical College, Chicago.

°Kampinga, Jurrien, Chicago, died October 21, at the age of 58. He was a 1949 graduate of the University of Amsterdam.

°Koeppl, Arthur, Chicago, died recently at the age of 87. He was a 1920 medical school graduate from Wren, Austria.

°Lorber, Maurice, Chicago, died November 7, at the age of 69. Dr. Lorber was a 1939 graduate of the Abraham Lincoln School of medicine. He was on the staff of Mt. Sinai Hospital and the faculty of Rush Medical College.

°Lusk, Frank B., Chicago, died October 15, at the age of 89. He was a 1914 graduate of Rush Medical College.

°Lydon, Sean B., Chicago, died in July, at the age of 44. He was a 1960 graduate of the University of Ireland.

°°Pick, John F., Chicago, died October 12, at the age of 78. He was a 1925 graduate of Rush Medical College. During his medical carcer, Dr. Pick was affiliated with Columbus and Illinois Masonic Hospitals. He was also the chief plastic surgeon for the Army's 4th service command and for the Illinois penitentiaries from 1937 to 1965.

Reis, Ralph A., Chicago, died September 7, 1978 at the age of 82. He was a professor emeritus of obstetrics and gynecology at Northwestern University Medical School, where he had held academic posts since 1923. Dr. Reis was a 1920 graduate of Northwestern University Medical School. He served his internship and residency at Michael Reese Hospital and did his postgraduate work in Vienna and Berlin.

°Sandburg, Carl Ludwig, Decatur, died September 24, at the age of 72. He graduated from Rush Medical College in 1941 and was a former president of the Macon County Medical Society.

°Swanson, Elmer E., Florida, died October 27, at the age of 88. He was a 1926 graduate of Rush Medical College and former chief of staff at South Chicago Community Hospital.

°Zurndorfer, Walter, Florida, died August 31, at the age of 82. Dr. Zurndorfer was a 1922 graduate of the University of Wurzburg, Germany, and a former Chicagoan.

*°Indicates ISMS member.*
*°°Indicates member of the ISMS Fifty Year Club.*

Bernice C. Uznanski, an ISMS employee for over 14 years, died on October 28. A former president of the ISMS Auxiliary, Mrs. Uznanski had served as secretary to the ISMS Committee on Drugs and Therapeutics and also administrative assistant to the Illinois Association of the Professions.


**COOK COUNTY**
**Graduate School of Medicine**

CONTINUING EDUCATION COURSES
STARTING DATES—1979

SPECIALTY REVIEW THORACIC SURGERY, January 29
SPECIALTY REVIEW NEUROLOGICAL SURGERY, February 2
CLINICAL MEDICINE, UPDATE, 5 days, March 19
NEUROLOGY, PART I, BASIC, February 26
BASIC REVIEW IN PSYCHIATRY, 5 days, March 12
SPECIALTY REVIEW SURGERY, PART II, March 12
CLINICAL & LABORATORY DIAGNOSIS OF HEMORRHAGIC AND THROMBOTIC DISORDERS, 2 days, March 23
ADVANCES IN SURGERY, 5 days, April 9
SPECIALTY REVIEW UROLOGY, 5 days, April 9
STATE & NAT'L. BD. REV., BASIC, April 15, CLINICAL, April 23
RADIATION ONCOLOGY, 5 days, April 23
GENERAL & DIAGNOSTIC RADIOLOGY, 5 days, April 23
SPECIALTY REVIEW OBGYN, April 30
SPECIALTY REVIEW FAMILY PRACTICE, May 7
SPECIALTY REVIEW ANESTHESIOLOGY, May 13
REVIEW, MEDICAL SUB-SPECIALTIES, May 7, 14, 21

*Information concerning numerous other continuation courses available upon request.*

**Address:**
**REGISTRAR, 707 South Wood Street,**
**Chicago, Ill. 60612**




# Tolinase®
## tolazamide, Upjohn

Please contact your Upjohn representative for additional product information.

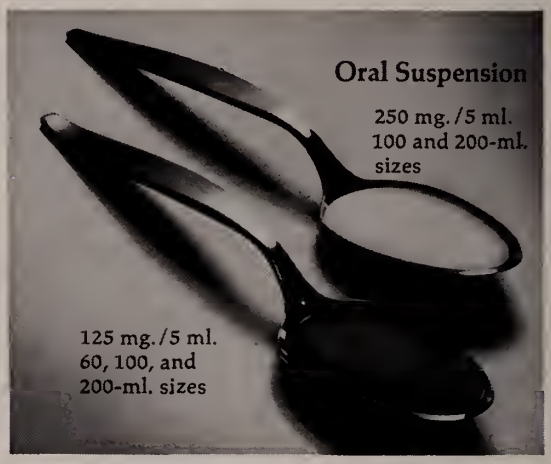
Upjohn

J-5695-6

©1977 THE UPJOHN COMPANY

# easy to take







## Keflex®
## cephalexin

Lilly

500738

*Additional information available to the profession on request.*
Eli Lilly and Company
Indianapolis, Indiana 46206

IMJ
Illinois Medical Journal
Vol. 154, No. 6, December, 1978

## Seventh Case in the Literature

# Scrotal Hernia Associated with Carcinoma of the Colon

By Harry L. Miller, M.D., Smiljan Puljic, M.D., and Harry Gordimer, M.D./New York

*The frequent association of colonic carcinoma in patients with inguinal hernia has often been cited.*[1-5] *The purpose of this paper is to report on a case of colonic carcinoma in an inguinal scrotal hernia sac. The rarity of such a lesion has prompted the report as only six other cases can be found in the literature.*[4]

An 80-year-old white male was admitted to the hospital with rectal bleeding and weight loss of approximately 15 pounds over a three month period. Bilateral scrotal hernias had been symptomatic during almost his entire life. Repair of the right scrotal hernia 30 years before had not prevented recurrence. On physical examination, he was an obese male with reducible bilateral scrotal hernias.

Upper gastrointestinal bleeding was initially suspected because of a clinical history of dark stools. However, barium enema revealed a large polypoid mass in the sigmoid colon which had herniated into the left scrotal area. The upper gastrointestinal series demonstrated a small hiatus hernia and right scrotal hernia.

At laparotomy, a well differentiated adenocarcinoma of the sigmoid colon was noted within a reducible left scrotal hernia together with peritoneal and liver metastases. A palliative resection of the left colon was undertaken with end-to-end anastomosis. Following uneventful recovery, the patient was discharged for further follow-up.

### Discussion

Many authors have pointed out the frequent association of colonic carcinoma with pre-exis-



HARRY L. MILLER, M.D., is o rodiologist affiliated os on associate professor with the Albert Einstein College of Medicine in New York. A diplomat of the Americon College af Radiology speciolizing in diagnastic radiolagy, Doctor Miller received his medical educotion in London, Englond.

HARRY GORDIMER, M.D., F.A.C.S., is a general surgeon offiliated as a consultont with the Bronx-Lebonon Hospital Center ond olso Lincoln Haspital in New York.

SMILJAN PULJIC, M.D., is a board certified rodiologist offilioted with the Bronx-Lebanon Hospital Center in New York. Doctar Puljic is alsa an assistont prafessar in radiology affiliated with the New York Medical College.



**Figure 1**
**Barium enema demonstrating an inguinal hernia with a filling defect in the herniated sigmoid due to a sigmoid carcinoma.**

tent inguinal hernia.[1-5] However, in addition, the reported number of inguinal hernias in patients with carcinoma of the colon has nearly tripled.[1,3] According to this author (John W. Maxwell, M.D. *et al.*) the appearance of an inguinal hernia may lead to a diagnosis of an asymptomatic carcinoma of the colon. In 107 of these cases (of colon lesion)[3] in 1963, 17% sought medical advice for symptoms referrable to an inguinal hernia. The series was enlarged to include 218 cases of carcinoma of the colon[3] with 49 (22%) reporting a diagnosis of carcinoma together with inguinal hernia.

It has been stated[2] that a search for large bowel disease should be made when an elderly patient presents with an inguinal hernia of recent origin, recent recurrence, or recent onset of symptoms. Sigmoidoscopy and barium enema are strongly recommended in all patients over 55 years old who have been selected for elective inguinal herniorrhaphy.[1] It is generally accepted that change in bowel habits and rectal bleeding may be the first indications of colonic carcinoma, and that any sudden or recurrent intra-abdominal pressure in the elderly is a factor in the genesis of inguinal hernia.

On the contrary, Brendel and Kirsch,[6] find a lack of association between inguinal hernia and carcinoma of the colon. In 312 patients with inguinal hernia who had pre-operative barium enemas, no case of carcinoma was noted. Patients who had colonic cancer did not show a higher prevalence of inguinal hernia than others of the same age without carcinoma. Rogers, *et al.*,[7] reported a case where an inguinal hernia resembled carcinoma of the sigmoid on barium enema, and suggested that the internist or radiologist should be alerted to attempt to reduce the hernia prior to performing a barium enema.

Carcinoma of the colon may cause an irreducible inguinal hernia but this is rare[4] and due possibly to the size of neoplasm, adhesions or edema of sac contents. In a series of 23 patients with colonic carcinoma, six patients were hospitalized merely for their hernias with asymptomatic large bowel disease and no signs referrable to colonic carcinoma.[1] According to the findings of Maxwell, *et al.*, in the age group between 55 and 64 years, 27.5% of the patients with colonic carcinoma had inguinal hernias, whereas, from a random questionnaire, the incidence of hernia in the general male population of that age group is 5.2%. Carcinoma of the colon can develop in a hernia and the association is more than coincidental.


## Summary

A case of carcinoma of the colon presenting in an inguinal scrotal hernia with review of the literature on the subject. ◄


## References


1. Davis, W. C., Jackson, F. C.: "Inguinal Hernia and Colon Carcinoma," *Ca—A Cancer Journal For Clinicians,* 18:3, 143-145, 1968.
2. Health Statistics from United States National Health Survey, PHS Publication, No. 584, B; 25 Washington, United States Government Printing Office, 1960.
3. Maxwell, J. W., Davis, W. C., Jackson, F. C.: "Colon Carcinoma and Inguinal Hernia," *Surg. Clin. of North America,* 45:1165-1171, 1965.
4. Sodhi, M. S.: "Carcinoma of the Colon Causing an Irreducible Left Inguinal Hernia," *Brit. J. of Clin. Practice,* 19:12, 707, 1965.
5. Terezis, N. L., Davis, W. C. and Jackson, F. C.: "Carcinoma of the Colon Associated with Inguinal Hernia," *New England J. of Med.,* 268:774-776, 1963.
6. Brendel, T. H., Kirsch, I. E.: "Lack of Association Between Inguinal Hernia and Carcinoma of the Colon," *New England J. Med.,* 284:7, 369-370, 1971.
7. Rogers, A. I., Herman, I. & Kalser, M. H.: "Inguinal Hernia Simulating Carcinoma of the Colon on Roentgenologic Examination after Barium Enema," *Diseases of the Colon and the Rectum,* 8:198-200, 1965.

*Case Report*

# Spontaneous Pneumopericardium

By Charles L. Lansford, M.D. and Jack C. Cooley, M.D./Urbana

*Pneumopericardium is a rare occurrence. Shackelford's complete review of the literature[2] reported several causes and others have been added to this list subsequently[1,3-5] but none of these were believed to be a late complication of surgical repair for hiatal hernia. We report such a case here.*

The patient was a 54-year-old white female, registered nurse, who first presented to our clinic early in 1975, with severe left shoulder pain. Her past history revealed three upper abdominal surgical procedures to correct gastroesophageal reflux and the complications of the reflux. She first underwent a Thal repair of a strictured esophagus in 1967. A stormy postop course with high fever necessitated re-exploration in two weeks, but according to the records no source of fever was found. Dysphagia had recurred and dilations were necessary. A Nissen repair was performed by the abdominal approach seven years after the initial surgery. She was symptom free until January, 1975, when she was seen in the Carle Clinic Rheumatology Department for left shoulder pain. When no local cause of the pain was found, esophagogastroduodenoscopy was performed but failed to reveal any signs of inflammation or abnormalities of the esophagus or stomach.

The pain was moderately severe and did not respond well to analgesic medications. A phrenic nerve block was successful in eradicating the pain, but the effects were temporary. A phrenic crush relieved the pain. In October, 1975, the patient experienced a recurrence of her left shoulder pain, as well as dyspnea. Admission chest X-ray revealed a pneumopericardium and a breakdown of her hiatal hernia repair with upward migration of the esophagogastric junction. The possibility of an associated rupture of a pulmonary bleb into the pericardium was considered. The patient had a benign course, remained afebrile, and the pneumopericardium resolved over four days.

She returned a month later with severe dyspnea, left shoulder and precordial pain, and diaphoresis and faintness. X-rays revealed a large pneumopericardium and a crunching sound could be heard in the anterior precardial area. After an afebrile, benign course, she was taken to surgery.

## Surgery

At surgery, a left posterolateral incision was made entering the pleural space through the seventh intercostal space. The pleural space was relatively free. The left lung was retracted superiorly, and this disclosed a large portion of the stomach in the chest area where the old Nissen repair had been previously carried out. The stomach wall was found on inspection to be densely adherent to the pericardium. Accordingly, a nasogastric tube was passed into the stomach

CHARLES L. LANSFORD, M.D., is a board certified internist and gastroenterologist affiliated with University of Illinois School of Basic Medical Science in Urbana, and the Carle Clinic Association.

JACK C. COOLEY, M.D., is a board certified cardiovascular and thoracic surgeon affiliated with the Carle Clinic Association in Urbana. He is also an associate professor of surgery for the UI College of Medicine and clinical assistant professor of physiology at the University of Illinois. Doctor Cooley is a member of the board of governors for the American College of Surgeons and a past president of the Illinois Surgical Society.

and tapes were placed around the esophagus above and the stomach below. A two inch square area of pericardium where the stomach and pericardium were adherent was then resected. It was then possible to retract the area of the sutured Nissen repair and the pericardium from the remainder of the pericardial sac. Using a probe, a small fistulous hole could be demonstrated that connected the pericardium and the portion of the stomach above the diaphragm. This fistulous tract was carefully closed using interrupted 3.0 silk sutures. The pericardial window was left open. Multiple cultures of pleural fluid and pericardial fluid were made. A catheter was left in the pleural space for drainage, and the chest was closed in a routine fashion. The patient had a most uneventful postoperative course and was dismissed from the hospital on the ninth postoperative day. She has had no further problems with left shoulder or chest pain.

## Discussion

A review of the literature reveals many causes of pneumopericardium, most reporting cases with a stormy course and eventual death.[3-5] Symptomatically, most cases present as an acute catastrophe resembling myocardial infarction or massive pulmonary embolism with sudden chest or upper abdominal pain and collapse. Some demonstrate precordial tympany with shifting dullness over the precordium and mechanical splashing sounds synchronous with systoli *(bruit de roue hydroulique).*

Our case appears to be remarkable in its very benign course and in the suspected etiology: a suture-induced fistula between the stomach and pericardium. No evidence of ulceration, tumor, or previously reported cause for the pneumopericardium was found in this patient. This small size and superior location of a fistula apparently prevented solid material or significant liquid gastric contents from reaching the pericardium and thereby apparently prevented a more fulminating pericarditis.

Pneumopericardium is another potential complication of hiatal hernia repair. ◄

## References


1. Barrett, N. R.: "Spontaneous Perforation of the Oesophagus," THORAX: I (Bibliography) 1:48-70, 1946.
2. Shackelford, R. B.: "Hydropneumopericardium," *JAMA* 96:181-187, 1931.
3. Gottesman & Bendich: "Pneumopericardium From Radiation Necrosis," *Am. J. Med. Sci.,* 3 171: 715-719, 1926.
4. Liu, D. H., Krastnopol, P., & Phillips, W.: "Perforation of a Gastrojejunal Ulcer into the Pericardium," *Arch. Surg.,* 94:294-298, 1967.
5. Monro, J. L., *et. al.*: "Gastropericardial Fistula, A Complication of Hiatal Hernia," *Br. J. Surg.,* 445-447, 1974.



LOW-COST GROUP INSURANCE ANOTHER ISMS MEMBERSHIP PRIVILEGE

**THE GROUP DISABILITY PLAN** ● Provides up to $1,732.00 monthly in the event of disability caused by Accident or Sickness. ● Special Guaranteed renewal feature. ● Protect your income and security.

**BUSINESS OVERHEAD EXPENSE PLAN** ● Pays your office overhead expense when disability strikes. ● Premiums are Tax Deductible. ● Pays in Addition to the Disability Plan Benefits.

**THE BASIC MAJOR MEDICAL EXPENSE PLAN** ● In or out of Hospital Benefits up to $25,000.00 per Disability. ● Up to $100.00 Daily Hospital Room and Board maximum. ● Subject to choice of deductible and 80% coinsurance.

**EXCESS MAJOR MEDICAL PLAN** ● Provides up to $500,000 for Medical Expenses. ● Supplements any Basic Major Medical Plan and is available with a $15,000, $20,000 and $25,000 deductible. Low group rates. ● Truly catastrophic coverage.

FOR INFORMATION, ASSISTANCE & DETAILS CONTACT:

Administrators:

PARKER, ALESHIRE & COMPANY
ESTABLISHED 1901
Insurance

9933 Niles Center Road
Skokie, Illinois 60077
Phone: 312-679-1000

## Case Report

# High Altitude Pulmonary Edema

By Thomas S. Kim, M.D./Arlington Heights

*High altitude pulmonary edema (HAPE) has been described with increasing frequency in medical literature. This entity is ordinarily localized to high altitude geographic areas. Due to the increased mobility of modern society and rapid speed of transportation today, however, it may not be unusual to be confronted with such an entity in the Midwest. A typical case of high altitude pulmonary edema was seen during the past winter in a northwest suburb of Chicago.*

A thirty-year-old Hawaiian-born male was admitted to the intensive care unit complaining of chest congestion and dyspnea. He had just flown back from Montana, where he had been skiing for two days at an altitude of eight to ten thousand feet. On the second day of skiing he became aware of extreme fatigue and dyspnea. He also noticed mild chest discomfort accompanied by cough and pink frothy sputum production. As he had experienced a similar episode approximately one year ago, the patient decided to return home for medical attention. Within 12 hours he sought medical attention at the hospital.

### Past Medical History

This patient's general medical history was unremarkable and noted no specific cardiac or pulmonary illnesses in the past. Until two years ago he had never climbed to an altitude of higher than three or four thousand feet. A year ago he had spent several days skiing in Colorado at an altitude of eight to eleven thousand feet, and after several days had developed symptoms consisting of cough, chest discomfort and dyspnea. He was hospitalized for four days and at discharge, was told that he may have high altitude pulmonary edema. Since this episode in Colorado, the patient reported no respiratory symptoms until his most recent experience in Montana.

### Clinical Findings

Physical examination revealed a young, healthy male who appeared mildly dyspneic with a respiratory rate of 26 at rest. Positive findings were confined to the chest where breath sounds were noted to be decreased with rales at the bases. Cardiac examination revealed a regular rhythm with no significant murmurs or gallops. Neck veins were flat. There was no clubbing or peripheral edema. Physical



THOMAS S. KIM, M.D., is a board certified anesthesiologist and internist affiliated with Northwest Community Hospital in Arlington Heights. The medical director of the intensive care unit and respiratory therapy departments, Doctor Kim is particularly interested in critical care medicine.

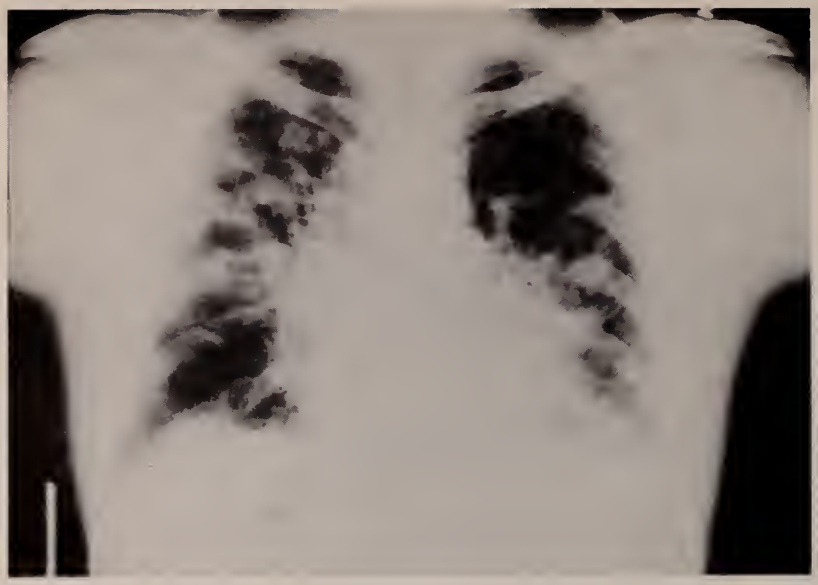


**Figure 1A**
**Patient X-Ray on Admission**



**Figure 1B**
**Patient X-Ray on Discharge**

examination was otherwise negative.

**Laboratory Data**

Chest X-ray at admission revealed a fluffly, patchy infiltrate bilaterally with a normal cardiac silhouette. Arterial blood gases on room air showed a $PCO_2$ of 35, $PO_2$ of 41 and PH of 7.46 with an oxygen saturation of 80%. CBC revealed a WBC of 11,500 with normal differential; hemoglobin was 16.7 Gm and hematocrit, 50%. MVC was 96, MCH was 31.7 and MCHC was 33.3. Serum proteins and EKG were normal.

**Hospital Course**

The patient was admitted to the intensive care unit where he was put to bed rest and placed on a high flow oxygen delivery system of 35% Venturi mask. His symptoms rapidly improved, along with the arterial blood gases. After three days of hospitalization he was discharged with near normal blood gases and an entirely normal chest X-ray. (See Figures 1 and 2)

**Discussion**

HAPE was specifically described by Houston followed by Hultgren and others who have since reported clinical and physiologic studies of this entity.[1,2] Although the mechanism of HAPE is obscure and controversial, the clinical and the physiological data are relatively uniform. The following is a summary of the clinical and laboratory data of HAPE.

**Clinical Setting**

The severity and the rapidity of onset for symptoms are variable, but frank pulmonary edema usually appears within 12-48 hours after ascent to heights generally greater than eight thousand feet. It appears that young males are more susceptible than older males or females. HAPE may occur for the first time in those who have never been exposed to high altitudes as well as in those who are re-entering the high altitude areas. Those who have experienced HAPE are apparently more prone to develop this syndrome again. These patients have no pre-existing cardio-pulmonary diseases and physiologic studies usually demonstrate no abnormal findings.

**Signs and Symptoms**

Patients with HAPE have the usual symptoms of pulmonary edema including cough, hemoptysis, shortness of breath, dyspnea on exertion, and chest discomfort. Physical findings include rales, and cyanosis if severely hypoxemic.

**Arterial Blood Gases**
**Figure 2**

| ADMISSION | $FIO_2$ | $PCO_2$ | $PO_2$ | PH | SAT % |
|---|---|---|---|---|---|
| 1st day | Room Air | 40 | 41 | 7.44 | 80 |
| 2nd day | 35% | 35 | 70 | 7.42 | 95 |
| 3rd day | 35% | 40 | 88 | 7.41 | 97 |
| DISCHARGE 1 MONTH | Room Air | 41 | 90 | 7.39 | 98 |

Some patients have shown signs of acute right heart strain with right ventricular heave, accentuated pulmonic sound of the second heart sound. Neck veins are usually flat. Peripheral edema is quite unusual. They may have a low grade fever as well as leucocytosis in variable degrees. Radiologically, characteristic findings are those of a non-cardiac pulmonary edema with patches of irregular, fluffy infiltrates more commonly seen in upper and mid lung fields with no evidence of cardiomegaly. EKG is normal or non-specific. Blood gases show variable degrees of hypoxemia with arterial desaturation.

Hemodynamic findings consistently show increased pulmonary artery (PA) pressure, normal or decreased wedge pressure or left atrial pressure, normal or decreased cardiac output.[3-5] More specific studies have shown that HAPE patients have diminished hypoxemic and hypercapneic ventilatory drive as compared to normals.[6]

## Theories

There are many theories to explain this entity, but none so far have explained the epidemiologic, clinical, and physiologic findings to complete satisfaction. Since the most uniform physiologic finding is that of abnormally elevated pulmonary arterial pressure without increased left ventricular pressure, most theories propose to explain this phenomena.

Autopsy findings have confirmed pulmonary edema in the lungs without pneumonia or heart failure so that pneumonia, once attributed to this entity, is now unfounded. Evidence of disseminated intravascular coagulation (DIC) has been demonstrated in post-mortem studies by some, but its role in the pathogenesis of pulmonary edema has not been clarified. Some authors have attributed pulmonary venous constriction, arteriolar constriction and nonuniform arterial veno constriction of pulmonary vasculature as a response to hypoxemia as the pathogenesis of pulmonary edema.[7] A concept of "preterminal arteriole" has been recently proposed to explain the process of regional edema and hypoxemia, in effect causing a right to left shunting.[8] It is apparent that none of the proposed theories fully explain the pathogenetic mechanism of high altitude pulmonary edema.

## Treatment

Since the exact mechanism of pulmonary edema is not clear, therapy, to say the least, is also controversial. Probably the most important factors are bed rest and adequate oxygen therapy and descent to lower altitude for the more seriously ill. Pharmacologically, such drugs as digitalis, morphine, aminophyllin, diuretics and steroids have been advocated, but good data as to their specific efficacy is lacking. Since left heart failure has been found not to be the etiology of the pulmonary edema, most authors seem to agree that digitalization is not an important adjunct to therapy. The use of Furosemide prophylactically, especially in regard to preventing acute mountain sickness, has been advocated by Singh,[9] but certainly there is no general agreement as to its efficacy. Although there is no specific therapy, most patients respond well to oxygen, bed rest, and descent to a lower altitude.

## Summary

In conclusion, as recreations such as mountain climbing and skiing become more popular, high altitude pulmonary edema and other associated high altitude illnesses such as cerebral edema and acute mountain sickness may be seen more frequently. In addition, due to various modes of rapid transportation today, more people are being exposed to high altitudes without being acclimatized. This also pertains to return from these areas. For this reason, HAPE may be observed in low altitude areas such as the Midwest. ◄

## References

1. Houston, C.: "Acute Pulmonary Edema of High Altitude," *New Eng. Journ. Med.*, 263:478, 1960.
2. Hultgren, H., Spickard, W., Hellriegel, K., and Houston, C.: "High Altitude Pulmonary Edema," *Medicine*, 40:289, 1961.
3. Hultgren, H., Lopez, C., Lundberg, E., Miller, H.: "Physiologic Studies of Pulmonary Edema at High Altitude," *Circulation*, 29: 393, 1964.
4. Hultgren, H., *et. al,*: "Abnormal Circulatory Responses to High Altitude in Subjects with a Previous History of High-Altitude Pulmonary Edema," *Circulation*, 44:759, 1971.
5. Penaloza, D.: "Circulatory Dynamics During High Altitude Pulmonary Edema," *Am. Jrn. Cardiology*, 23:369, 1969.
6. Lakshminarayan, S., Pierson, D.: "Recurrent High Altitude Pulmonary Edema with Blunted Chemosensitivity," *Am. Review of Resp. D.*, 111: 1975.
7. Kleiner, J., Nelson, W.: "High Altitude Pulmonary Edema, a Rare Disease?" *JAMA*, 234:5, 491, 1975.
8. Recavarren, S.: "The Preterminal Arterioles in the Pulmonary Circulation of High Altitude Natives," *Circulation*, 33:177-180, 1966.
9. Singh, I.: "High Altitude Pulmonary Edema," *Am. Heart J.*, 70: 435, 1965.

# Doctors !

## How important is it for you to keep up to date with advances in your field?



# Very Important !

## Well, it is also important for your medical assistants.

## How would they do this?

With the Certified Medical Assistant (CMA) Exam Review and Refresher Course. It is an intensive review which covers:

Anatomy and Physiology
Medical Terminology

Business (Administrative) Procedures

Clinical Procedures

How to Study

How to Take Tests

Medical Law and Ethics

This course is designed for students and practicing medical assistants to prepare them for successful examination or as a comprehensive refresher for certified medical assistants.

**When** Sessions will be held on two weekends in January prior to the national exam date.

1st session is January 13,14
2nd session is January 20,21
8:30 – 5:00, all dates

(Textbook to be purchased at the time of the first class.)

---

For further information on this Chicago seminar, contact instructors:

Judith A. Miller, CMA - AC
Triton College 456 - 0300, x 293
and
Vera Murchison, R.N., CMA - C
Harper College 397 - 3000, x 444

# Summary of Actions

# 1978 Interim Sessions

# Of the House of Delegates

*The House of Delegates took the following actions on resolutions and reports considered by:*

## REFERENCE COMMITTEE ON AMENDMENTS TO CONSTITUTION AND BYLAWS

1. Amended the Bylaws to delineate concerns of the Council on Medical Service as: (A) provision of medical and health services in the public and private sectors; (B) emergency medical services; (C) health care for the poor, the aged and rural residents; (D) maternal and child health; (E) nutrition; (F) workmen's compensation; (G) environmental and community health; (H) rehabilitation; and (I) health care facilities and delivery systems. (78N-17)
2. Amended the Bylaws to provide for a Board of Trustees Committee on Third Party Payment Processes to consider issues or problems requiring high-level negotiations with third-party payers. (78N-16)
3. Referred to the Board of Trustees for study a resolution which would revise the areas of concern of the Council on Economics and Peer Review. (78N-15)
4. Amended the Bylaws to create an independent Judicial Panel to handle ethical relations matters, removing that responsibility from the Board of Trustees and the Ethical Relations Committee. The five member Panel—elected by the House—will hear all appeals and adjudicate disputes on ethical affairs involving component societies, district committees and ISMS. Under the Panel system, county societies retain the option of maintaining an ethical relations committee or delegating its responsibilities to a district body. The Panel will accept appeals only after the case has been heard at the local level. Appeals based upon new evidence will be referred back to the local committee for possible rehearing. The Judicial Panel will intervene only when a component society fails to act in a timely manner. Decisions of the Judicial Panel are final, unless an appeal is feasible under the Constitution and Bylaws of the AMA. To ensure uniformity in handling cases at all levels, the Panel will prepare for House approval a *Handbook for the Conduct of Disciplinary Proceedings.* Elected to the Panel were Drs. Howard Burkhead, Evanston, 5½ yrs., Frank Norbury, Jacksonville, 4½ yrs., Herschel Browns, Chicago, 3½ yrs., Eugene Johnson, Casey, 2½ yrs., J. Robert Thompson, Oak Park, 1½ yrs. (78N-25, 26, 27, 28, 29, 30)
5. Approved creation of a Peer Review Appeals Committee reporting directly to the Board of Trustees. The Committee will hear appeals by any party based upon bias, incomplete information, substantive or procedural error. The House also adopted the following definition of peer review:

   Peer review is the inclusive term for medical review by practicing physicians of the utilization of medical services, quality of care, professional competency and patient relations issues. Medical society peer review shall be conducted at the local level whenever possible. Major ethical relations questions identified during deliberations of the Peer Review Appeals Committee shall be appropriately referred. (78N-48, 49)
6. Amended the Bylaws to expand responsibilities of the Council on Affiliate Societies to include initiation of recommendations to the Board of Trustees on legislative matters affecting any specialty society. (78N-18)
7. Referred to the Board of Trustees for study a resolution intended to restrict kinds of

business to be considered at Interim Sessions of the House of Delegates. In the interest of efficiency, the resolution would permit introduction of only urgent matters at Interim Sessions. (78N-19)

8. Transferred the Tazewell County Medical Society from the Fifth to the Fourth Trustee District. This change was initiated to bring compatability to Tazewell County's HSA, PSRO and Trustee District designations. (78N-24)
9. Referred to the Board of Trustees for study a resolution to expand the duties of the Illinois State Medical Society president. (78N-47)

## REFERENCE COMMITTEE "A"

1. Revised a policy statement on committee appointments to limit individual tenure on ISMS committees to a maximum of five years. (78N-5)
2. Deleted the following statements from the ISMS policy manual: (A) "Education, Primary and Secondary," (B) "Facility Medical Boards (Physicians)," (C) "Federal Funds," (D) "Relative Value," and (E) "Ethics." (78N-6, 8, 12)
3. Referred to the Board of Trustees for study a resolution to delete the statement, "Fee Schedules," from the ISMS policy manual. (78N-11)
4. Rejected a resolution to allocate one delegate and one alternate delegate position on the Illinois Delegation to the AMA to resident members. (78N-23)
5. Rejected a resolution to seek lower malpractice premiums in the interest of cost containment. (78N-20)
6. Directed the Board of Trustees to investigate the feasibility of the Illinois State Medical Inter-Insurance Exchange extending coverage to include protection of county society officers in performance of administrative duties. (78N-31)
7. Rejected a resolution mandating the Board of Trustees to report to the House on the implementation of previously adopted resolutions, noting that the intent of the resolution is being fulfilled and the additional statement was considered superfluous. (78N-35)
8. Encouraged hospital medical staffs to perform focused utilization review of all patients in selected diagnostic categories, regardless of the source of payment, and further urged all third party payers (private and governmental) to reimburse hospitals and physicians for time and expense of such utilization review. (78N-40)
9. Referred to the Board of Trustees for study a resolution regarding second opinion for surgery. The resolution called upon ISMS to: (A) oppose utilization of a closed panel of consultants, favoring usual and customary referrals; (B) oppose board certification as a referral criterion; and (C) favor the use of non-surgical specialists. (78N-42)
10. Referred to the Board of Trustees for study a resolution which would require information on any proposed dues increases and assessments to be distributed to delegates and county medical societies at least 30 days prior to formal consideration by the House of Delegates. (78N-43)
11. In response to a recent statement regarding conduct by the Association of American Medical Colleges, called upon the AMA to invite the Association of American Medical Colleges to present its views on ethics to the AMA for consideration and to reiterate AMA standing as representative for all U.S. physicians. (78N-59)

## REFERENCE COMMITTEE "B"

1. Approved revision in the policy manual to update statements entitled "Public Aid" and "Comprehensive Health Planning." (78N-9, 13)
2. Directed the Society to take action to prevent third party access to the physician's own private medical practice business records without appropriate legal authority assuring due process. (78N-34)
3. Directed the Illinois Delegation to the AMA to introduce a resolution supporting: (A) stronger local and state control of the health planning process and (B) appropriate amendments to P.L. 93-641 to make HSAs directly responsive to their constituent national legislators on a regular basis in matters related to HSA fund utilization, accomplishments and/or problems. (78N-36)
4. Reaffirmed ISMS opposition to compulsory governmentally mandated national health insurance plans and instructed the Illinois Delegation to the AMA to oppose introduction by the AMA of any further national health insurance legislation. (78N-60)

## REFERENCE COMMITTEE "C"

1. Referred to the Board of Trustees for study a resolution regarding medical school admission criteria and physician distribution in Illinois. (78N-1)
2. Rejected as improper a proposal to delete from the policy manual the statement entitled "Nurses-Shortage." (78N-10)
3. Determined that authors or discussants at programs for which ISMS is the primary fiscal sponsor be asked to submit original papers to *IMJ* for publication consideration with the right of first acceptance or refusal. (78N-21)
4. Rejected a resolution which would have had ISMS oppose any efforts to define or classify human life. (78N-22)
5. Encouraged AMA to oppose development of any JCAH standard mandating medical staff membership to anyone other than fully licensed physicians and dentists. (78N-32)
6. Endorsed the Voluntary Effort to Control Health Care Costs, and supported the concept that physicians should help to moderate medical care costs. (78N-33, 57)
7. Rejected a resolution regarding ISMS policy on cost containment, the intent of which is fulfilled through the Task Force on Cost Effectiveness. (78N-41)
8. Referred to the Board of Trustees for study a resolution suggesting that ISMS establish a physician negotiating agency as a membership service. (78N-46)
9. Expressed continuing support for the Illinois Council on Continuing Medical Education, reaffirming ISMS position on ICCME funding as defined by the House at the 1978 annual meeting. Mandated strict budgetary review and suggested an increase in fees for ICCME services prior to consideration of deficit spending. (78N-37, 52, 53)

## REFERENCE COMMITTEE "D"

1. Referred to the Board of Trustees for study a proposal to gather and disseminate information on actual costs of government health insurance programs now in effect, including the proportion subsidized by physicians in giving medical care to indigent persons. (78N-2)
2. Deleted from the policy manual obsolete statements: (A) asking the Illinois State Medical Inter-Insurance Exchange to maintain in its bylaws a guarantee of due process, (B) requiring that upper level ISMS representatives and local physicians be included in planning and development of Illinois health programs financed by government funding, and (C) encouraging ISMS participation in Community Health Week. (78N-3, 4, 14)
3. Encouraged initiation of legislation to designate "Code Blue Care"—defined as institutionally designated, life threatening emergencies requiring CPR—as a "Good Samaritan" act. (78N-38)
4. Adopted a set of guidelines for physician professional advertising. The guidelines—which shall apply to solo-practitioners and groups of physicians—are suggested for medical groups, clinics, hospitals and medical institutions. They are not intended for utilization in any legislative activity. They are intended to allow physician advertising which is in compliance with the AMA Principles of Medical Ethics and current rules of law, and which does not promote or produce unfair competition. (78N-39)
5. Referred to the Board of Trustees for study certain suggestions in the advertising guidelines referred to above. Those items referred relate to advertising of fees, changes in professional identification, accepted forms of remuneration and overt solicitation. (78N-39)
6. Authorized ISMS to initiate legislative action to assure that hospital admission, (including initial and subsequent involuntary certification) treatment and discharge procedures related to mental and physical illness remain in all cases the exclusive responsibility of a physician licensed to practice medicine in all its branches. (78N-50)
7. Encouraged physicians to seek family approval for postmortem examination in all deaths, emphasizing the educational benefits of autopsy. (78N-51)
8. Authorized the Society to seek legislative reform of the legal system to implement Article 1, Section 12 of the Illinois Constitution which would facilitate countersuits against frivolous malpractice litigation. (78N-54).
9. Encouraged legislation providing legal defense, indemnification and, when appropriate, immunity for physicians serving state and local government agencies as vol-

unteers, independent contractors or employees. (78N-55)

10. Opposed a proposed OSHA rule concerning access to individual, identifiable employee medical records as contrary to law and medical confidentiality, and incompatible with the best interests of the patient and public policy. Directed the Society to: (A) provide testimony by a physician knowledgeable in occupational medicine at upcoming OSHA hearings; and (B) ask the AMA to follow suit. (78N-58).

## OLD BUSINESS

At its 1978 Annual Meeting, the House of Delegates referred resolutions which pertained to recommendations of the National Commission on the Cost of Medical Care to the Board of Trustees for study. The 1978 AMA Annual Meeting House of Delegates acted on 30 Commission recommendations. The ISMS Board of Trustees responded to each of those actions. This Interim Session House ratified ISMS Board response in each instance.

Report A of the ISMS Board of Trustees requested House action on matters which had been referred to the AMA Board for study and will be debated at the December AMA Interim Meeting House of Delegates. The ISMS Board had sent recommendations for AMA Board study, and now asked the Interim Session House to review those actions. The House approved or amended those recommendations in resolution form, acting as follows:

1. Endorsed the concepts of neutral public policy and fair market competition among all health care delivery systems and asked the AMA Board to seek objective assessment of HMOs, including IPAs and other group arrangements, with respect to impact on health care access, quality and cost. (78A-51)
2. Asked the AMA to: (A) urge the Health Insurance Association of America and Blue Cross/Blue Shield to refrain from providing policies which penalize patients for selecting their physicians' offices for performance of medical and surgical procedures; and (B) support adjustment of governmental and private insurance benefit packages to provide balanced coverage of alternative settings and services. (78A-55)
3. Endorsed the concept of voluntary planning, mandating that planning legislation should continue to be monitored in terms of cost, benefits, effectiveness and administrative activities to fulfill federal requirements. Opposed public utility-type regulation of the medical profession. Found the certificate of need to be a non-proven concept requiring continued evaluation. (78A-60)
4. Endorsed implementation of voluntary programs to achieve "decertification" or conversion of facilities found to exceed community needs on an experimental basis. (78A-62)
5. Reaffirmed support for appropriate preventive care and early detection screening services, specifying that the necessity of these services should be evaluated on the bases of appropriateness and cost. (78A-43)
6. Advocated establishment of regulatory systems to certify and monitor the performance of third party payers for fiscal responsibility and accurate representation of premium or capitation costs and benefits which would not inhibit third party efforts to develop innovative approaches to coverage. (78A-31)

In response to Board Report B, the House of Delegates took the following action on another resolution referred to the Board for study at the 1978 Annual Meeting:

1. Rejected as unfeasible a proposal to launch a massive public information campaign aimed at repealing P.L. 93-641, the National Health Planning and Resource Development Act. (78A-12)

In response to Board Reports C and D, the House of Delegates took the following actions on resolutions referred to the Board for study at the 1977 Interim Meeting:

1. Rejected a resolution requesting a feasibility study at selected hospitals considering seven-day versus five-day institutions on the basis of investigation by the Task Force on Cost Effectiveness. (77N-52)
2. Stipulated that ISMS will continue to investigate adequacy of health care availability and needs. (77N-50)

## SPECIAL ACTIONS

1. Endorsed a memorial resolution extending sympathy to the family of Joseph L. Bordenave, M.D. Dr. Bordenave, of Geneva, was a former chairman of both the ISMS Board of Trustees and the ISMIS Board of

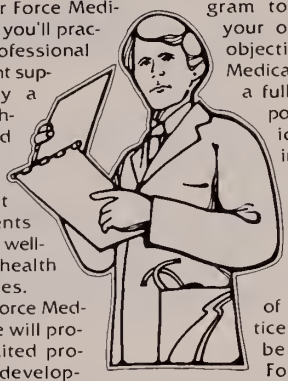
Trustees. The resolution cited his years of service as a practicing physician and a leader of organized medicine.

2. Extended sympathy to the family of David C. Christy, M.D., a Watseka physician and former president of the Iroquois County Medical Society. The resolution commended years of leadership both in his profession and his community.

3. Voted to name Jacob E. Reisch, M.D., former ISMS secretary-treasurer, Honorary ISMS President. Dr. Reisch, Springfield, is a former delegate to the AMA, as well as former ISMS trustee and delegate to the House. The resolution read in part: "No physician has served this Society more faithfully or is more deserving of the highest honor it can bestow."

4. Robert R. Hartman, M.D., presented a plaque to Eugene Balthazar, M.D., citing six years of "unparalleled public service by a member of the medical profession." Dr. Balthazar was lauded for establishing a free medical clinic, which he maintained at personal expense from 1972-78, to serve indigent citizens of Aurora.


**Physicians: we treat you seriously in the Air Force**



As an Air Force Medical Officer, you'll practice in a professional environment supported by a team of highly qualified technical assistants. You'll treat your patients in modern, well-equipped health care facilities.

The Air Force Medical Service will provide unlimited professional development, with a carefully designed individual program to complement your own skills and objectives. Air Force Medical Centers offer a full range of opportunities in clinical medicine, including clinical investigation.

Avoid the time consuming burdens of private practice. Consider the benefits of Air Force medicine. Health care at its very best.

Capt. Stephen Dewoody
Air Force Recruiting Squadran
12th and Spruce Streets
St. Lauis, Missauri 63102
Call Collect: 314-268-2471/2238

Air Force. A great way of life.

★
*Specialized Service*
IN
PROFESSIONAL LIABILITY INSURANCE
*is a high mark of distinction*

Since 1899

THE
MEDICAL PROTECTIVE COMPANY
FORT WAYNE, INDIANA

CHICAGO AREA OFFICE:
T. J. Pandak, J. C. Kunches, L. R. Gannan, and W. G. Prangle, Representatives
814 Commerce Drive, Suite 109, Oak Braak, Illinais 60521 (312) 325-7314
SPRINGFIELD OFFICE: W. J. Nattermann, Representative
426½ Sauth Fifth Street, Springfield 62701 (217) 544-2251

# Actions on Resolutions November, 1978 Interim Meeting House of Delegates

| *Number* | *Introduced By:* | *Subject* | *Action* |
|---|---|---|---|
| **Reference Committee on Constitution & Bylaws** | | | |
| 78N-15 | James Laidlaw for Board of Trustees | Amendment to Chapter IX, Section 2, of the Bylaws Revising Areas of Concern of Council on Economics & Peer Review | Referred to B of T |
| 78N-16 | James Laidlaw for Board of Trustees | Amendment to Chapter IX of the Bylaws Describing the Committee on Third Party Payment Processes | Adopted |
| 78N-17 | James Laidlaw for Board of Trustees | Amendment to Chapter IX of the Bylaws to Describe the Areas of Concern of the Council on Medical Services | Adopted |
| 78N-18 | James Laidlaw for Board of Trustees | Amendment to Chapter IX of the Bylaws Expanding the Charge to the Council on Affiliate Societies | Adopted as editorially corrected |
| 78N-19 | P. John Seward for Board of Trustees | Streamlining Operation of the Interim Session of the House of Delegates | Referred to B of T |
| 78N-24 | Robert Tucker | Transferring Tazewell County Medical Society to the 4th Trustee District | Adopted |
| 78N-25 | James Laidlaw for Board of Trustees | Revision of Chapter XI of the Bylaws | Adopted as amended & editorially corrected |
| 78N-26 | James Laidlaw for Board of Trustees | Amendment to Chapter IV—House of Delegates By Adding a New Section 12 to be Titled: *Judicial Panel* | Adopted |
| 78N-27 | James Laidlaw for Board of Trustees | Repeal of Section 2C—Judicial Duties of Chapter VII—The Board of Trustees | Adopted |
| 78N-28 | James Laidlaw for Board of Trustees | Deletion of Section 6D of Chapter IX—Committees | Adopted |
| 78N-29 | James Laidlaw for Board of Trustees | Chapter X—County Societies—Revision Section 5 | Adopted |
| 78N-30 | James Laidlaw for Board of Trustees | Amendment to the Constitution | Adopted |

| *Number* | *Introduced By:* | *Subject* | *Action* |
|---|---|---|---|
| 78N-47 | George T. Wilkins<br>Clifton L. Reeder | Duties of the President | Referred to B of T |
| 78N-48 | A. Everett Joslyn | Revisions in Peer Review | Adopted |
| 78N-49 | A. Everett Joslyn | Definition of Peer Review | Adopted as editorially corrected |
| **Reference Committee "A"** | | | |
| 78N-5 | Lawrence L. Hirsch for Board of Trustees | Revision of Policy on Committee Appointments | Adopted |
| 78N-6 | Lawrence L. Hirsch for Board of Trustees | Deletion of Administrative Polices—Education, Primary & Secondary; Facility Medical Boards (Physicians) and Federal Funds—from Policy Manual | Adopted |
| 78N-7 | Lawrence L. Hirsch for Board of Trustees | Revision in Policy Statement on Specialty Society Representation on ISMS Councils | Withdrawn |
| 78N-8 | Lawrence L. Hirsch for Board of Trustees | Deletion of Relative Value Statement from Policy Manual | Adopted |
| 78N-11 | Lawrence L. Hirsch for Board of Trustees | Deletion of Statement on Fee Schedules from Policy Manual | Referred to B of T |
| 78N-12 | Lawrence L. Hirsch for Board of Trustees | Deletion of Ethics Statement from Policy Manual | Adopted |
| 78N-20 | Samuel J. Schimel | Lowering Malpractice Insurance Rates as Cost Containment Measure | Rejected |
| 78N-23 | James DeBord | Resident Delegate from Illinois to AMA House of Delegates | Rejected |
| 78N-31 | James P. Campbell | Liability Coverage for Medical Society Officers | Adopted |
| 78N-35 | J. R. O'Donnell | Reporting on the Implementation of Resolutions | Rejected |
| 78N-40 | Morris T. Friedell for Board of Trustees | Utilization Review of All Patients | Adopted as amended |
| 78N-42 | Robert R. Hartman for Board of Trustees | Second Opinion for Surgery | Referred to B of T |
| 78N-43 | Ernest Adams | Distribution of Information Regarding Dues & Assessments | Referred to B of T |
| 78N-44 | George T. Wilkins | AMA Delegation Operation Under Unit Rule Concept | Withdrawn |
| 78N-45 | George T. Wilkins | Membership List by Legislative Districts | Withdrawn |
| 78N-56 | Walter Stevenson | Second Opinions Before Surgery Requested by Insurance Companies | Not considered |

| *Number* | *Introduced By:* | *Subject* | *Action* |
|---|---|---|---|
| 78N-59 | Lawrence L. Hirsch | The Establishment of Ethical Standards | Adopted |
| 78N-61 | David S. Fox | Second Opinion for Surgery | Not considered |
| 78A-50 Old Business | *Board of Trustees* | Economic Incentives in Purchasing Insurance and Health Plans | Ratified B of T Action in Lieu of 78A-50 |
| Substitute 78A-51 Old Business | *Board of Trustees* | Fair Market Health Plan Competition | Substitute for Substitute 78A-51 adopted |
| 78A-52 Old Business | *Board of Trustees* | Alternative Financing Arrangements | Ratified B of T Action in Lieu of 78A-52 |
| 78A-53 Old Business | *Board of Trustees* | Information on Alternate Health Care Plan Benefits | Ratified B of T Action in Lieu of 78A-53 |
| 78A-54 Old Business | *Board of Trustees* | Reimbursement Levels for Providers | Ratified B of T Action in Lieu of 78A-54 |
| Substitute 78A-55 Old Business | *Board of Trustees* | Utilization in Appropriate Settings | Substitute for Substitute 78A-55 adopted |
| 77N-52 Old Business | Robert L. Cavens | Health Care Institutions Functioning 7 Days | Rejected |
| **Reference Committee "B"** | | | |
| 78N-9 | Lawrence L. Hirsch for Board of Trustees | Revision of Public Aid Statement in Policy Manual | Adopted |
| 78N-13 | Lawrence L. Hirsch for Board of Trustees | Revision of Policy Statement on Comprehensive Health Planning | Adopted |
| 78N-34 | Kenneth Hurst | Illinois Department of Public Aid Invasion of Privacy | Adopted as amended |
| 78N-36 | Ronald M. Severino | Health Planning at State Level | Substitute adopted as amended |
| 78N-60 | David S. Fox | National Health Insurance | Substitute adopted as amended |
| Substitute 78A-58 Old Business | *Board of Trustees* | Reimbursement Restrictions | Ratified B of T Action in Lieu of 78A-58 |
| Substitute 78A-59 Old Business | *Board of Trustees* | Incentives to Limit Bed Capacity | Ratified B of T Action in Lieu of 78A-59 |
| Substitute 78A-60 Old Business | *Board of Trustees* | Planning | Substitute for Substitute 78A-60 adopted as editorially amended |
| 78A-61 Old Business | *Board of Trustees* | Certificate of Need | Ratified B of T Action in Lieu of 78A-61 |

| *Number* | *Introduced By:* | *Subject* | *Action* |
|---|---|---|---|
| 78A-62<br>Old Business | *Board of Trustees* | Decertification | Substitute adopted as amended |
| 78A-63<br>Old Business | *Board of Trustees* | Regional Centers | Ratified B of T<br>Action in Lieu of 78A-63 |
| 78A-64<br>Old Business | *Board of Trustees* | Capital Expenditure Limits | Ratified B of T<br>Action in Lieu of 78A-64 |
| 78A-68<br>Old Business | *Board of Trustees* | Placement Review Criteria | Ratified B of T<br>Action in Lieu of 78A-68 |
| 78A-12<br>Old Business | Melvin Freedman | Substitute Proposal for P.L. 93-641 National Health Planning & Resource Development for 1974 | Rejected |
| **Reference Committee "C"** | | | |
| 78N-1 | M. B. Kirschenbaum | Medical School Admissions and Physician Shortage Areas | Referred to B of T |
| 78N-10 | Lawrence L. Hirsch for Board of Trustees | Deletion of Statement on Nurses Shortage from Policy Manual | Rejected |
| 78N-21 | Robert R. Hartman for Board of Trustees | IMJ Publication of Clinical Materials from ISMS-Sponsored Meetings | Substitute adopted as editorially corrected |
| 78N-22 | H. Frank Holman | How Then Shall We Define Life? | Rejected |
| 78N-32 | Thomas W. Stach | Joint Commission on Accreditation of Hospitals | Substitute adopted |
| 78N-33 | Morgan M. Meyer | Cost Containment | Adopted 78N-57 in Lieu of 78N-33 |
| 78N-37 | C. A. DeKovessey | Evaluation of Continuing Medical Education | Substitute 78N-53 Adopted in Lieu of 78N-37, 52 & 53 |
| 78N-41 | John W. Ovitz | Illinois State Medical Society Policy on Cost Containment | Rejected |
| 78N-46 | George T. Wilkins | Physicians' Negotiating Agency | Referred to B of T |
| 78N-52 | Gregory G. Spano | Value of ICCME to Illinois Physicians | Substitute 78N-53 Adopted in Lieu of 78N-37, 52 & 53 |
| 78N-53 | Gregory G. Spano | Evaluation of Continuing Medical Education | Substitute adopted |
| 78N-57 | Clifton L. Reeder | Cost Containment | Adopted |
| 78A-40<br>Old Business | *Board of Trustees* | Assessment & Assurance of Quality of Care | Ratified B of T<br>Action in Lieu of 78A-40 |
| Substitute 78A-41<br>Old Business | *Board of Trustees* | Criteria & Use of Practice Evaluation Techniques | Ratified B of T<br>Action in Lieu of 78A-41 |
| Substitute 78A-42<br>Old Business | *Board of Trustees* | Inappropriate Medical Care | Ratified B of T<br>Action in Lieu of 78A-42 |

| *Number* | *Introduced By:* | *Subject* | *Action* |
|---|---|---|---|
| Substitute 78A-43 Old Business | *Board of Trustees* | Preventive Services | Substitute for Substitute 78A-43 adopted as amended |
| 78A-44 Old Business | *Board of Trustees* | Multiphasic Health Evaluations | Ratified B of T Action in Lieu of 78A-44 |
| 78A-45 Old Business | *Board of Trustees* | Health & Patient Education | Ratified B of T Action in Lieu of 78A-45 |
| 78A-46 Old Business | *Board of Trustees* | Incentives to Provide Appropriate Care | Ratified B of T Action in Lieu of 78A-46 |
| 78A-47 Old Business | *Board of Trustees* | Diagnostic Findings | Ratified B of T Action in Lieu of 78A-47 |
| 78A-48 Old Business | *Board of Trustees* | Technology Assessment & Information Dissemination | Ratified B of T Action in Lieu of 78A-48 |
| 78A-49 Old Business | *Board of Trustees* | Research Toward Cost-Savings Innovations | Ratified B of T Action in Lieu of 78A-49 |
| 78A-71 Old Business | *Board of Trustees* | Supply Guidelines | Ratified B of T Action in Lieu of 78A-71 |
| 78A-72 Old Business | *Board of Trustees* | Physician Supply | Ratified B of T Action in Lieu of 78A-72 |
| 78A-73 Old Business | *Board of Trustees* | Professional Attractiveness | Ratified B of T Action in Lieu of 78A-73 |
| 78A-74 Old Business | *Board of Trustees* | Loan Forgiveness and Scholarships | Ratified B of T Action in Lieu of 78A-74 |
| 78A-75 Old Business | *Board of Trustees* | Recruitment from Underserved Areas | Ratified B of T Action in Lieu of 78A-75 |
| 78A-76 Old Business | *Board of Trustees* | Family Practice | Ratified B of T Action in Lieu of 78A-76 |
| 78A-77 Old Business | *Board of Trustees* | Curricula on Economics of Health Care | Ratified B of T Action in Lieu of 78A-77 |
| 78A-78 Old Business | *Board of Trustees* | Limit Restrictions on Defusion of New Technologies | Ratified B of T Action in Lieu of 78A-78 |
| 77N-50 Old Business | Robert L. Cavens | Shortage of Health Care Personnel & Facilities | Substitute adopted |
| **Reference Committee "D"** | | | |
| 78N-2 | M. B. Kirschenbaum | Government Influence on Cost of Medical Care | Referred to B of T |
| 78N-3 | Lawrence L. Hirsch for Board of Trustees | Revision in Policy Statement on Professional Liability | Adopted |
| 78N-4 | Lawrence L. Hirsch for Board of Trustees | Deletion of Policy Statement on Medical Representation in Gov't. Planning | Adopted as amended |

| *Number* | *Introduced By:* | *Subject* | *Action* |
|---|---|---|---|
| 78N-14 | Lawrence L. Hirsch for Board of Trustees | Deletion of Community Health Week Statement from Policy Manual | Adopted |
| 78N-38 | Morgan M. Meyer | Code Blue Care | Adopted |
| 78N-39 | George T. Wilkins for Board of Trustees | Physician Professional Advertising Guidelines | Adopted as amended (Section II, No. 11 & 12, Section III, No. 8 & 10, referred to B of T) |
| 78N-50 | J. R. O'Donnell | Hospital Admission, Care & Discharge Responsibility of Physicians | Adopted |
| 78N-51 | C. B. Lara | Declining Number of Autopsies | Adopted as amended |
| 78N-54 | Wayne N. Leimbach | Illinois State Medical Society to Seek Legislative Redress for the Injured Innocent | Adopted as amended |
| 78N-55 | Robert T. Fox for Board of Trustees | Indemnification of Physicians Employed by State or Local Governments | Adopted |
| 78N-58 | Audley F. Connor, Jr. | Opposition to Proposed Rule Giving OSHA Employees Access to Patient Records | Adopted as amended |
| Substitute 78A-31 Old Business | *Board of Trustees* | Regulation of Insurance Carriers & Health Plans | Substitute for Substitute 78A-31 adopted as amended |
| Substitute 78A-32 Old Business | *Board of Trustees* | Prospective Rate Setting for Hospitals | Ratified B of T Action in Lieu of 78A-32 |
| 78A-33 Old Business | *Board of Trustees* | Evaluating Public Utility Regulation & Exemptions From It | Ratified B of T Action in Lieu of 78A-33 |
| 78A-34 Old Business | *Board of Trustees* | Review of Regulatory Process | Ratified B of T Action in Lieu of 78A-34 |
| 78A-35 Old Business | *Board of Trustees* | Modify Restrictions on Allied Health Personnel | Ratified B of T Action in Lieu of 78A-35 |
| 78A-69 Old Business | *Board of Trustees* | Defensive Medicine | Ratified B of T Action in Lieu of 78A-69 |

The following resolutions were considered by the House of Delegates without referral to a Reference Committee:

| | | |
|---|---|---|
| Robert R. Hartman | Memorial Resolution—Joseph L. Bordenave, M.D. | Adopted |
| Kenneth A. Hurst | Memorial Resolution—David C. Christy, M.D. | Adopted |
| Robert R. Hartman for Board of Trustees | Honorary ISMS President—Jacob E. Reisch, M.D. | Adopted |

# *Board Abstracts*

*(Continued from page 392)*

- *Counterclaims/Malicious Prosecution:* Expand the definition of malicious prosecution to enable physicians to sue without the requirement of special damages and to permit the filing of such counterclaims in the original cause of action, without having to wait for a favorable verdict.
- *Section 41:* Require courts to hold hearings on motions filed under Section 41 of the Illinois Civil Practice Act. Currently, the court may refuse to hear the motion which, if granted, would force plaintiffs to pay defense costs in frivolous suits.

The Society also will seek legislation to: (1) Permit physicians to treat minors for alcohol intoxication without parental consent; (2) Define attacks on emergency room personnel as a Class 3 felony (aggravated battery); and (3) Exempt from the legal "discovery" process records of the Illinois State Medical Inter-Insurance Exchange peer review committee.

ISMS will oppose any legislation requiring annual license renewal based on testing of clinical competence and CME accomplishment. House Proposal 148—mandating the requirement—is pending in the General Assembly and could be introduced as legislation during the next session.

## Physician Recruitment

ISMS will survey county medical societies, hospital administrators and health service agencies in an effort to identify medically underserved areas of Illinois. Survey results will enable the ISMS Committee on Physician Recruitment to assess area manpower "needs" from three perspectives, rather than relying solely upon physician-patient ratios. The Society was directed last year by the House of Delegates to identify areas having an acute shortage of health care personnel and facilities, and to study inequities among those areas.

In a related action, the Board placed the Physician Recruitment Program and Doctor's Job Fair under the purview of the Council on Education and Manpower—parent body of the Committee on Physician Recruitment. The Job Fair and Recruitment Program previously were operated as administrative activities.

## New Health Practitioners Committee

ISMS will appoint a Committee on New Health Practitioners to monitor activities involving all classes of so-called "physician extenders." The Committee will function under the Council on Education and Manpower.

## Cost Containment

As a result of the House of Delegates' approval of Resolution 78N-40—which urged hospital medical staffs to perform focused UR of all patients—the Task Force on Cost Effectiveness will develop a pilot project utilizing appropriate alternatives to inpatient hospital care, with comparable coverage by third party payers. ISMS also will: (1) Encourage institutions and their medical staffs participating in focused review to explore alternatives to in-hospital care and report their findings to the Task Force; and (2) Lend whatever resources are available to support these demonstration projects.

ISMS also will explore the development of an ongoing education program on cost effectiveness—with a detailed curriculum of training resources—for presentation to hospital medical staffs. In preparing the program, ISMS will seek the cooperation of the Illinois Hospital Association, Chicago Hospital Council, Blue Cross/Blue Shield and participating hospitals.

The Illinois State Cost Containment Committee—a joint ISMS-Illinois Hospital Association group charged with implementing the Voluntary Effort to control health costs—will be urged to implement, if feasible, a pilot project modeled after a program in Utah based upon the "swing-bed" concept. Under the program, under-utilized acute care beds are used for long-term care patients. Society representatives to the ISCCC will suggest that the ISCCC consider encouraging medical staffs to: (1) Establish cost benefit committees with broad departmental participation; and (2) Inform the ISCCC of its implementation by January 1.

## Generic Consent Form

The Illinois Department of Public Health will be urged to incorporate an ISMS-developed patient consent form into regulations governing the generic substitution law. The form would be signed by a patient to authorize the pharmacist to substitute a generic drug. It is designed to help monitor the substitution program, prevent inappropriate substitution and afford some liability protection to physicians. If IDPH does not mandate use of the form via regulation, ISMS will seek legislation requiring its use.

## Co-Sponsor Seminars

ISMS will co-sponsor the following seminars:

- *Mental Health Code* (co-sponsors Illinois Department of Mental Health and Developmental Disabilities and Illinois Hospital Association): Designed to acquaint physicians and hospital administrators with ramifications of the new Code. Two meetings—one in Chicago and the other in Springfield—are slated for November and December.
- *Fetal Alcoholism Syndrome* (co-sponsors Illinois Nurses Association and March of Dimes): Scheduled for June 18, 1979. Program and specific location to be announced in near future.
- *Physicians' Workshop on Epilepsy* (co-sponsor University of Illinois' Comprehensive Program for Children with Epilepsy): Scheduled for May '79 in Chicago. Possible topics include: Seizures in children; seizures associated with operative lesions; legal implications of epilepsy; and relationship between epilepsy and learning disabilities.
- *Medical-Legal Seminar* (co-sponsor American Society of Law & Medicine); Scheduled for April 19, at Peoria Hilton Hotel. Topic will be legal pitfalls in medical practice.

The Board approved sponsorship of a practice management seminar during the 1979 ISMS annual meeting, provided its producer—V. Mueller Company—agrees to guidelines formulated by the Board. The all-day session—titled "Establishing Yourself in a Private Practice"—also was presented at the 1978 annual meeting.

## Special Committee Formed

A special ad hoc committee-composed of past ISMS presidents and Board chairmen —was formed to study the duties of the ISMS president, Board chairman and executive administrator . . . and the operating interrelationships of ISMS, IFMC, ICCME, ISMIS and ISMIE. The committee—which will function without staff assistance and report to the Board next March—will be co-chaired by Dr. George Wilkins, immediate past president, and Dr. Robert Fox, immediate past Board chairman. Other members are: Drs. Joseph Skom, Jerry Ingalls, Fredric Lake, William Lees and Willard Scrivner.

## Reimbursement Denial

ISMS will study the feasibility of creating a patient advocate committee to assist in resolving reimbursement denials by private carriers and government. In studying the retrospective denial issue, ISMS will ask the Illinois Hospital Association to survey its member institutions to determine the extent of hospital reimbursement denial.

## AMA Chiropractic Suit

The Illinois Delegation to AMA was instructed to work for conciliation of the split between the American College of Radiology and AMA over the Association's acceptance of settlement terms in the highly-publicized chiropractic suit in Pennsylvania. The Illinois Delegation was instructed to deal with the problem "according to established policies of ISMS, backed up by their best judgment based on background, experience and serious consideration, in an effort to conciliate this dangerous division in the house of medicine."

## CME/ICCME

The Board voted to support ICCME's proposed 1979 programs—which includes employing a professional educator—that will be funded by the $10 AMA-ERF allocation plus that amount necessary to accomplish goals coming from general funds. The ISMS Finance Committee will consider the ICCME budget annually in terms of accomplishing its stated goals . . . and base its recommendations on the total funds available for allocation rather than a per capita amount.

In other action concerning ICCME, the Board:

- Directed that management of ICCME should be by its executive director who is responsible to the ICCME Board, which, in turn, is responsible to the ISMS Board.
- Directed the Planning and Priorities Committee to consider the possibility of reducing the size of the ICCME Board and change the composition so that it is primarily made up of ISMS Board members. All members would be approved by the ISMS Board.
- Approved the suggestion of the Planning and Priorities Committee to control ICCME finances via deficit financing . . . and approve ICCME's aims and goals with subsequent approval of the budget.

ISMS will not seek accreditation to grant Category I credit for CME programs. Instead, ICCME—which already has the accreditation—will be asked to co-sponsor CME programs meeting requirements for Category I. Last June, the Board voted to seek accreditation in the interest of programming freedom, which now can be obtained by ICCME co-sponsorship.

The Board approved an increase in CME accreditation fees effective January 1, but will continue to waive the registration fee for county medical societies. Meanwhile, the Board will urge the national Liaison Committee on CME to institute several revisions in its proposed changes in the types and duration of accreditation.

## Second Opinion Programs

ISMS will voice objection to the Health Insurance Association of America over policies which provide a lesser benefit if the patient undergoes elective surgery: (1) Without seeking a second opinion; or (2) Despite a second opinion which does not confirm the need for the procedure. The programs also utilize the "closed panel" arrangement which forces patients to obtain the second opinion from those physicians listed on a roster formulated by the program's sponsor. ISMS also will register an objection with the Prudential Insurance Company which is marketing such a plan in Illinois.

## IDVR Advisory Committee

ISMS has recommended to the Illinois Division of Vocational Rehabilitation that its soon-to-be-formed Medical Advisory Committee should: (1) Review counselors' performances and evaluators' reports; and (2) Establish liaison with specialty groups, particularly the Illinois Physician Medical and Rehabilitation Society and the Illinois Academy of Family Practice. In addition, the Society recommended that IDVR's relationships with facilities should require that the institution is accredited by the Commission on Accreditation of Rehabilita-

tion Facilities. ISMS emphasized that the relationships should take into account a patient's geographic and personal needs and not be limited to institutions favored by counselors.

## Student Business Section

County medical societies will be encouraged to organize and provide assistance to local components of the Student Business Session (SBS) and Resident Physicians Section (RPS). The Board noted that while SBS and RPS assure student and resident input into ISMS activities, its does not activate them on the local level. Component societies which have medical schools within their counties will be asked to appoint a representative to a special ISMS committee charged with coordinating the activities of these local groups. The Illinois Delegation to AMA will urge the Association to encourage state and county societies throughout the country to assist state and local SBS and RPS components.

## IDPA Drug Manual

The following drugs were approved for inclusion in the IDPA Drug Manual: Parlodel, Florone Ointment, Florone Cream, Quibron Plus Elixir, Quibron Plus Capsules, Simecone Suspension, and Westcort (Hydrocortisone Valereate) Cream 0.2% (under dermatologic preparations).

## Appointments/Nominations

The Board approved the following appointments:

- *Dr. Warren Tuttle,* Harrisburg—Committee on Accreditation
- *Dr. Donald Ferguson,* Chicago—Committee on Physician Recruitment
- *Dr. Joseph O'Donnell,* Glen Ellyn—consultant, Committee on Health Planning
- *Dr. Robert Johnson,* Springfield—consultant, Student Business Session
- *Dr. Jere Freidheim,* Chicago—consultant, Resident Physicians Section
- *Drs. Leroy Levitt,* Chicago; and *Donald Sellers,* Park Ridge—Panel for the Impaired Physician
- *Dr. Michael Van Dyce Hinken,* Rockford—Scientific Speakers Bureau of the Alcoholism Education Program
- *Cyril L. Friend, D.D.S.,* Metropolis—State Technical Advisory Committee to ISMS Jail Health Project (upon recommendation of Illinois State Dental Society)

ISMS Past President Dr. Jerry Ingalls, Paris, was named to assume January chairmanship of the Illinois State Cost Containment Committee—a joint ISMS-Illinois Hospital Association group charged with implementing the Voluntary Effort in Illinois. The chairmanship alternates annually between Medical Society and Hospital Association appointees. Dr. Ingalls currently serves as ISCCC vice-chairman.

Dr. Henrietta Herbolsheimer, Chicago, was nominated for reappointment to the State Health Coordinating Council.

Nominated for appointment to the Illinois Health Facilities Planning Board's Committee to Study Regulation of Hospices were: Drs. Obert Lay, Granite City; Steven Cullinan and Irving Weigenberg, Peoria; Andre Lascari, Michael Stokes and Charles Wabner, Springfield; and Shirely Roy, Bertram Moss, Kermit Mehlinger and Edwin Miller, all of Chicago.

Nominated for appointment to the IDVR Medical Advisory Committee were: Drs. Aaron Rosenthal, Park Ridge; Hugh McMenamin, Peoria; Stephen Jarrett, Rock Island; Eric Ericson and Robert Lund of Rockford; and Kate Kohn, Henry Betts and Sidney Alpert of Chicago. Because rehabilitative service requires a team approach involving therapists and others in related fields, ISMS also nominated the following non-physicians: Herbert Schultz, C.P., and Barbara Nandzik, P.T., of Rockford; and William Gellman, Ph.D., Chicago.




# ISMS Interim Meeting RPS Chairman – Delegate's Report

By Linda L. Hughey, M.D./Wilmette

*This is a monthly column which welcomes contributions, comments, and questions from interested readers. Address all correspondence to Dr. Linda Hughey, c/o the Illinois Medical Journal, 55 E. Monroe, Chicago, Ill. 60603.*

*To The Resident Members of ISMS:*

The Interim Meeting of the ISMS House of Delegates was held in Rockton, Illinois on November 4th and 5th.

The meeting was attended by 3 resident representatives: B. Barry LeCompte, M.D., (Resident Housestaff Association, Rush-Presbyterian St. Luke's Hospital); James DeBord, M.D. (Chief Surgical Resident, University of Illinois Hospitals) and Ira J. Isaacson, M.D. (Senior Anesthesia Resident, Northwestern University). Dr. DeBord and Dr. Isaacson served as alternate delegate and delegate to the Interim Meeting for the residents.

The main issue for the residents at this time was a resolution submitted by the RPS which asked for a resident member (delegate and alternate) appointment to the Illinois Delegation to the AMA House of Delegates. This resolution had been defeated without discussion at the Annual Meeting in 1978.

At this Interim Meeting the resolution was discussed in detail by both proponents and opponents to the resolution. Some of the issues raised by the opponents included: (1) the lack of experience of residents in such political matters; (2) the length of service of such a delegate is often many years and by definition a resident would be a "short-term" member and (3) that residents should go through the regular county society channels for election to the Illinois Delegation to the AMA.

As proponents we argued: (1) the issues of statistical representation (there are 14 Illinois AMA delegates and not *13* because there are over 1,000 resident members of ISMS); (2) that residents in lengthy training programs could easily serve 2-4 year terms in the delegation; (3) that the residents are a separate special section as defined by the By-laws of this Society.

An additional point not raised but very pertinent to future discussion is that at the state level the resident section is a separate group. We are neither a part of the upstate nor downstate caucuses, which recommend AMA delegates and therefore we need not go through the regular channels at the county level.

The Reference Committee, after much deliberation agreed "that an effective AMA delegation depends upon the experience of physicians who can continue service for a long period of time. Nonetheless, the committee agrees that input from resident members is valuable, and that their continued participation should be encouraged." The Reference Committee recommended that our resolution be amended to provide for an *alternate* delegate position for a resident to the Illinois Delegation to AMA House of Delegates. The residents in attendance at the meeting felt that at this time, this recommendation was a reasonable compromise.

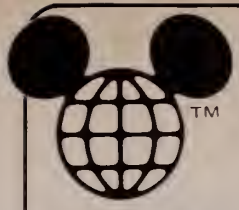
However, on the floor of the House of Delegates this proposed amended resolution was again discussed in detail. The opponents raised arguments similar to above. The discussion

seemed evenly divided between proponents and opponents. Unfortunatley, on a standing vote this amended resolution was *defeated* by the House of Delegates 91 for and 101 against. As this total (192) was greater than the number of voting delegates originally listed at the start of the session, a recount was requested and this request was defeated.*

This was a hotly contested issue and one which should be brought to the House of Delegates at each session until we are successful in this reasonable endeavor. We have (as the vote reflects) a significant amount of regular member support. I firmly believe we can succeed at the Annual Meeting in May, 1979.

Ira J. Isaacson, M.D.
Chairman, ISMS-RPS
ISMS Delegate

**Editor's Note: The number of delegates present at the time a vote is requested, rather than the number present for the opening tally, constitute voting strength. Delegates are not disenfranchised by tardiness.*

**REGISTER TODAY**
FOR THE FIRST ANNUAL
**WALT DISNEY WORLD**
PULMONARY WINTERCOURSE
JANUARY 15 - 18, 1979

Physicians, Respiratory Therapists, Nurses and allied medical professionals, this is your chance for a state-of-the-art update in pulmonary medicine while earning 28 credit hours in Category I of the Physicians Recognition Award of the AMA. You'll also enjoy the wonders of the world's number one vacation attraction, the Magic Kingdom of Walt Disney World.

You're in store for a high energy course featuring an outstanding faculty from Florida's leading medical schools. You'll have a chance to meet with your professional collegues from all parts of the country as they converge on the Contemporary Hotel.

There's even a thirty-seven booth trade exposition spotlighting the nation's key suppliers to the medical profession for you to enjoy.

Plan the highlight of your new year today by registering for this outstanding course.

Applications are available by writing or calling:
Asher Marks, M.D.
Florida Thoracic Society
P.O. Box 8127
Jacksonville, Florida 32211
Telephone: (904) 743-2933
Space is limited, so please act immediately.


# INDEX TO ADVERTISERS


## Pharmaceuticals

| | | |
|---|---|---|
| 395-398 | **Boehringer Ingelheim** | *Catapres* |
| 439 | **Burroughs Wellcome Co.** | *Cardilate* |
| Cover 2 | **Burroughs Wellcome Co.** | *Neosporin Topical* |
| 430 | **Jobst Laboratories** | *Breast Prostheses* |
| 404 | **Eli Lilly and Company** | *Keflex* |
| 435-436 | **Mead Johnson Pharmaceutical Div'n.** | *Colace*<br>*Vasodilan* |
| 389-390 | **Roche Laboratories**<br>**Div. of Hoffman LaRoche** | *Librax* |
| Covers 3-4 | **Roche Laboratories**<br>**Div. of Hoffman LaRoche** | *Librium* |
| 440-441 | **Schering Pharmaceuticals** | *Optimine* |
| 443 | **Smith Kline and French Labs.**<br>**Div. of SmithKline Corp.** | *Dyazide* |
| 450 | **Smith Kline and French Labs.**<br>**Div. of SmithKline Corp.** | *Isocult* |
| 403 | **Upjohn Pharmaceuticals** | *Tolinase* |

## Insurance

| | | |
|---|---|---|
| 448 | **Illinois State Medical Inter-Insurance Exchange** | *Professional Liability Insurance* |
| 417 | **Medical Protective Co.** | *Professional Liability Insurance* |
| 408 | **Parker Aleshire and Co.** | *Group Insurance* |

## Services and Continuing Education

| | | |
|---|---|---|
| 393-394 | **Blue Cross/Blue Shield Report** | |
| 451 | **Classified Advertising** | |
| 402 | **Cook County Graduate School of Medicine** | *Continuing Medical Education* |
| 429 | **Florida Thoracic Society** | *Continuing Medical Education* |
| 444 | **IMPAC** | |
| 437 | **ISMS Guide to Continuing Medical Education** | |
| 417 | **U.S. Air Force** | *Position Opportunity* |


*Our advertisers serve the Medical Profession and support your Journal. All advertisers are approved by your Journal Committee. It will help you and your society to mention your Journal when writing them.*

*Space Representatives:* United Media Associates. Inc., 16 Bruce Park Avenue, Greenwich, Conn. 06830



# Yours Truly™ by Jobst® — it's only natural.

Finally, a truly natural external breast prosthesis is available to your patients. No need to follow the trauma of a radical mastectomy and associated psychological overlay with an ugly, even grotesque breast prosthesis of unnatural polyvinyl chloride.

Now, with the help of your nurse, Reach to Recovery volunteers, and others, you can suggest to your postmastectomy patients an external breast form that is seamless and natural. The Yours Truly™ breast form is new. Worn right against the skin it requires no special bra to stay in place. It moves with the vitality and flow of a natural breast. The silicone gel inside has a specific gravity of .98, only .04 more dense than human breast tissue and the response in vivo is nearly identical. There are thirteen sizes from which to choose, each with the contour and suppleness of the female breast size it replaces.



**Contact your local Jobst Service Center for complete details.**

**JOBST CHICAGO SERVICE CENTER**

**Chicago, Illinois 60602**
Suite 2101, Pittsfield Bldg.
55 E. Washington Street
312/346-0446

# INDEX TO VOLUME 154

## July through December, 1978


| | |
|---|---|
| **July** | **pages 1-58** |
| **August** | **59-116** |
| **September** | **117-174** |
| **October** | **175-328** |
| **November** | **329-386** |
| **December** | **387-452** |



A

Ablin, Richard J., Ph.D., *Contributing Editor* **(SEMINARS IN IMMUNOLOGY AND ONCOLOGY)**
**ABSTRACTS OF ISMS BOARD OF TRUSTEES ACTIONS,** 4, 120, 392
Actions on Resolutions, 1978 Interim Session House of Delegates 418
Acute Unilateral Ankle Swelling With Fever **(RHEUMATOLOGY ROUNDS)** L. F. Layfer and J. V. Jones, *Contributing Co-Editors,* 320
Alcoholism, Screening For (Spalt) 348
Ancillary Organizations, ISMS **(REFERENCE ISSUE)** 254
Andrews, Brian S., BSc (MED), *jt. author,* Immune Complexes and Human Disease **(SEMINARS IN IMMUNOPATHOLOGY AND ONCOLOGY)** 85, 146, 366 (Richard J. Ablin, *Contributing Editor*) (Penny)
Arnold, William, *jt. author,* Disseminated Gonococcal Infection: Penicillin Responsiveness As An Aid In Differential Diagnosis (Loftin, Crane) 343
Ask A Consultant 75, 169

B

Balderman, Samuel C., *jt. author,* Bedside Barium Enema: A New Approach (Sriram, Michel) 29
Barium Enema, Bedside: A New Approach (Balderman, Michel, Sriram) 29
Beal, John M., *Contributing Editor,* **(SURGICAL GRAND ROUNDS)**
Bedside Barium Enema A New Approach (Balderman, Sriram, Michel) 29
Bennin, Bruce, *jt. author,* Factitial Panniculitis (Harisdangkul, Ellman, Fretzin) 358
Black, R., D.S.W., *jt. author,* The Comprehensive Program for Children With Epilepsy **(SPECIAL ARTICLE)** (Herman, Page-El, Zurbruugg, Chhabria) 140
Board of Trustees Actions, Abstracts of, 4, 120, 392
Branchial Cleft Cyst: Case Report **(SURGICAL GRAND ROUNDS)** John M. Beal, *Contributing Editor* 361
Byyny, Richard L., *jt. author,* The University Medical School Reaching To The Community Physician **(SPECIAL ARTICLE)** (Gunzburger, Kimball, Siegler, Tarlov) 81

C

Cacioppo, Phillip L., *jt. author,* Carcinoma Arising In A Thyroglossal Duct Cyst (Samaraweera) 79
Carcinoma Arising in a Thyroglassal Duct Cyst (Cacioppo, Samaraweera) 79
Case Report: Branchial Cleft Cyst **(SURGICAL GRAND ROUNDS)** John M. Beal, *Contributing Editor* 361
Case Report: Coronary Artery Surgery **(SURGICAL GRAND ROUNDS)** John M. Beal, *Contributing Editor* 36
Case Report: Cryptorchidism **(SURGICAL GRAND ROUNDS)** John M. Beal, *Contributing Editor* 143
Case Report: High Altitude Pulmonary Edema (Kim) 409
Case Report: Spontaneous Pneumopericardium (Lansford, Cooley) 407
Case Report: Phencyclidine Psychosis (Fauman, Fauman) 324
Cooley, Jack C., *jt. author,* Spontaneous Pneumopericardium **(CASE REPORT)** (Lansford) 409
Case Report: Torsion of the Testes **(SURGICAL GRAND ROUNDS)** John M. Beal, *Contributing Editor* 317
Chhabria, S., *jt. author,* The Comprehensive Program for Children With Epilepsy **(SPECIAL ARTICLE)** (Hermann, Page-El, Zurbruugg, Black) 140
Charts, ISMS Organization **(REFERENCE ISSUE)** 203, 235
Classified Advertising 44, 109, 170, 326, 316, 451
Clinics for Crippled Children 11, 61, 125, 179, 332, 389
Community Physician, The University Medical School Reaching To The, **(SPECIAL ARTICLE)** (Byyny, Gunzburger, Kimball, Siegler, Tarlov) 81

Comprehensive Program for Children with Epilepsy, The **(SPECIAL ARTICLE)** (Hermann, Page-El, Zurbruugg, Chhabria, Black) 140
Computerized Whole Body Tomography **(SURGICAL GRAND ROUNDS)** John M. Beal, *Contributing Editor* 90
Constitution and Bylaws, ISMS **(REFERENCE ISSUE)** 205
Consultant, Ask A, 75, 169
Continuing Medical Education, ISMS Guide To, 42, 111, 164, 200, 364, 437
Convention Program, 1978 Interim Session House of Delegates
Members of the House of Delegates 231, 296
County Medical Society Officers 299
Resolutions 309
Convention Summary, 1978 Interim Session House of Delegates
Summary of Actions, 413
Actions on Resolutions, 418
Cooper, Richard A., Viewbox Case of the Month for August, Leon Love, *Contributing Editor* 67
Coronary Artery Surgery: Case Report **(SURGICAL GRAND ROUNDS)** John M. Beal, *Contributing Editor* 36
Councils and Committees, ISMS **(REFERENCE ISSUE)** 236
Crane, Kenneth P., *jt. author,* Disseminated Gonococcal Infection: Penicillin Responsiveness As An Aid In Differential Diagnosis (Loftin, Arnold) 343
Creatine Phosphokinase Activity Elevation, Non-Cardiac (Damergis, Stoker) 138
Cryptorchidism, Case Report, **(SURGICAL GRAND ROUNDS)** John M. Beal, *Contributing Editor* 143

## D

Damergis, John A., *jt. author,* Non-Cardiac Creatine Phosphokinase Activity Elevation (Stoker) 138
DeHaen, Paul, **(NEW PHARMACEUTICAL SPECIALTIES)** 72
Delayed Hemolytic Transfusion Reaction (Lee) 135
Delegation to the AMA, ISMS **(REFERENCE ISSUE)** 304
Disapprove Concept, Not Method **(PRESIDENT'S PAGE)** (Fox) 375
Disseminated Gonococcal Infection: Pencillin Responsiveness As An Aid in Differential Diagnosis (Loftin, Crane, Arnold)

## E

Edwards, Larry D., *jt. author* Preliminary Report: A More Physiologic Skin Prep (Johnson) 352
**EKG OF THE MONTH** (John F. Moran, David J. Hale, Patrick J. Scanlon, Sarah A. Johnson, John R. Tobin and Rolf M. Gunnar, *Contributing Co-Editors*) 6, 63, 122, 188, 336, 399
Ellman, Michael, *jt. author,* Factitial Panniculitis (Harisdangkul, Bennin, Fretzin) 358
Epilepsy, The Comprehensive Program for Children With **(SPECIAL ARTICLE)** (Hermann, Page-El, Zurbrugg, Chhabria, Black) 140

## F

Factitial Panniculitis (Harisdangkul, Ellman, Bennin, Fretzin) 358
Fauman, Beverly J., *jt. author,* Case Report: Phencyclidine Psychosis (Fauman) 324
Fauman, Michael A., *jt. author,* Case Report: Phencyclidine Psychosis (Fauman) 324
Fox, David S. **(PRESIDENT'S PAGE)**
Fretzin, David E., *jt. author,* Factitial Panniculitis (Harisdangkul, Ellman, Bennin) 358

## G

Gonnococcal Infection: Penicillin Responsiveness As An Aid In Differential Diagnosis, Disseminated (Loftin, Crane, Arnold) 343
Gordimer, Harry, *jt. author,* Scrotal Hernia Associated with Carcinoma of the Colon (Miller, Puljic) 405
**GUEST EDITORIALS** 98, 192
Gunnar, Rolf M., *Contributing Co-Editor* **(EKG OF THE MONTH)**
Gunzburger, Linda K., M.S., *jt. author,* The University Medical School Reaching to the Community Physician **(SPECIAL ARTICLE)** (Byyny, Kimball, Siegler, Tarlov) 81

## H

Hale, David J., *Contributing Co-Editor,* **(EKG OF THE MONTH)**
Harisdangkul, Valee, *jt. author,* Factitial Paniculitis (Ellman, Bennin, Fretzin) 358
Hemolytic Transfusion Reaction, Delayed (Lee) 135
Hermann, B., Ph.D., *jt. author,* The Comprehensive Program for Children With Epilepsy **(SPECIAL ARTICLE)** (Page-El, Zurbruugg, Chhabria, Black) 140
High Altitude Pulmonary Edema **(CASE REPORT)** (Kim) 409
House of Delegates, ISMS **(REFERENCE ISSUE)** 231, 296
**HOUSESTAFF NEWS** Linda L. Hughey, *Contributing Editor* 95, 126, 332, 381, 428
Hughey, Linda L., *Contributing Editor* **(HOUSESTAFF NEWS)**
Human Disease, Immune Complexes and **(SEMINARS IN IMMUNOPATHOLOGY AND ONCOLOGY)** Richard J. Ablin, *Contributing Editor* (Andrews, Penny) 85, 146, 366

## I

Illinois Council on Continuing Medical Education 42, 111, 164, 200, 364, 437
Illinois State Government and Agencies **(REFERENCE ISSUE)** 263

Illinois Society, American Association of Medical Assistants 15, 108, 166, 378, 412
Illinois Voluntary Effort, The **(PRESIDENT'S PAGE)** (Fox) 105
Immune Complexes and Human Disease **(SEMINARS IN IMMUNOPATHOLOGY AND ONCOLOGY)** Richard J. Ablin, *Contributing Editor,* (Andrews, Penny) 85, 146, 366
Index to the Reference Issue **(REFERENCE ISSUE)** 286
Interim Session, 1978 House of Delegates
Convention Program 295
Convention Summary, 413
Interim Session to Focus on Key Issues **(PRESIDENT'S PAGE)** (Fox) 313
Intraspinal Schwannoma, Sudden Paraplegia Caused by an (Mansfield) 356
**ISMS**
Organizational Charts 203, 235
Constitution and Bylaws 205
Policy Manual 217
House of Delegates 231, 296
Councils and Committees 236
Services 247
Abstracts of Board Actions 4, 120, 392
Ancillary Organizations 254
Medical-Legal Information 281
Legislative Update 288
AMA Delegation Report 304
County Medical Society Officers 299
**ISMS Guide to Continuing Medical Education** 42, 111, 164, 200, 364, 437

**J**

Johnson, Hugh A., *jt. author,* Preliminary Report: A More Physiologic Skin Prep (Edwards) 352
Johnson, Sarah A., *Contributing Co-Editor* **(EKG OF THE MONTH)**
Jones, J. V., *Contributing Co-Editor* **(RHEUMATOLOGY ROUNDS)**

**K**

Kim, Thomas S., High Altitude Pulmonary Edema **(CASE REPORT)** 409
Kimball, Chase P., *jt. author,* The University Medical School Reaching to the Community Physician **(SPECIAL ARTICLE)** (Byyny, Gunzburger, Siegler, Tarlov) 81

**L**

Lansford, Charles L., *jt. author,* Spontaneous Pneumopericardium **(CASE REPORT)** (Cooley) 407
Layfer, L. F., *Contributing Co-Editor* **(RHEUMATOLOGY ROUNDS)**
Lee, Bak M., Delayed Hemolytic Transfusion Reaction 135
Legislative Update **(REFERENCE ISSUE)** 288
Loftin, Eugene B., *jt. author,* Disseminated Gonococcal Infection: Penicillin Responsiveness As An Aid In Differential Diagnosis (Crane, Arnold) 343
Love, Leon, *Contributing Editor* **(VIEWBOX)**

**M**

Mansfield, James B., Sudden Paraplegia Caused By An Intraspinal Schwannoma 356
Medical-Legal Information **(REFERENCE ISSUE)** 281
**Membership Forum** 154
Memon, Iqbal A., Organophosphate Poisoning **(PEDIATRIC PERPLEXITIES)** Ruth Andrea Seeler, *Contributing Editor* 32
Michel, Arthur G., *jt. author,* Bedside Barium Enema: A New Approach (Balderman, Sriram) 29
Miller, Harry L., *jt. author,* Scrotal Hernia Associated with Carcinoma of the Colon (Puljic, Gordimer) 405
Moran, John F., *Contributing Co-Editor* **(EKG OF THE MONTH)**
More Physiologic Skin Prep, Preliminary Report (Edwards, Johnson) 352

**N**

N.H.I. Drive Hits Snag **(PRESIDENT'S PAGE)** (Fox) 160
New Approach, Bedside Barium Enema (Balderman, Sriram, Michel) 29
**New Pharmaceutical Specialties** (DeHaen) 72
Non-Cardiac Creatine Phosphokinase Activity Elevation (Damergis, Stoker) 138

**O**

**Obituaries** 16, 73, 142, 190, 332, 402
Organizational Charts, ISMS **(REFERENCE ISSUE)** 203, 235
Organophosphate Poisoning **(PEDIATRIC PERPLEXITIES)** Ruth Andrea Seeler, *Contributing Editor* (Memon) 32

**P**

Page-El, E., *jt. author,* The Comprehensive Program for Children with Epilepsy **(SPECIAL ARTICLE)** (Hermann, Zurbruugg, Chhabria, Black) 140
Painful Anterior Shoulder Mass With Calcification **(RHEUMATOLOGY ROUNDS)** L. F. Layfer and J. V. Jones, *Contributing Co-Editors* 22
Panniculitis, Factitial (Harisdangkul, Ellman, Bennin, Fretzin) 358
Paraplegia Caused by an Intraspinal Schwannoma, Sudden (Mansfield) 356
**Pediatric Perplexities,** Ruth Andrea Seeler, *Contributing Editor,* Organophosphate Poisoning (Memon) 32
Penicillin Responsiveness as an Aid in Differential Diagnosis, Disseminated Gonococcal Infection (Arnold, Crane, Loftin) 343
Penny, Ronald, *jt. author,* Immune Complexes and Human Disease **(SEMINARS IN IMMUNOPATHOLOGY AND ONCOLOGY)** Richard J. Ablin, *Contributing*

*Editor* (Andrews) 85, 146, 366
Phencyclidine Psychosis, Case Report (Fauman, Fauman) 324
Phosphokinase Activity Elevation, Non-Cardiac Creatine (Damergis, Stoker) 138
Physician Recruitment 54, 115, 158, 314, 370, 442
Poisoning, Organophosphate **(PEDIATRIC PERPLEXITIES)** Ruth Andrea Seeler, *Contributing Editor* (Memon) 32
Policy Manual, ISMS **(REFERENCE ISSUE)** 217
Poma, Pedro A., *jt. author,* Rape: A Community Hospital Study (Stepto) 25
Preliminary Report: A More Physiologic Skin Prep (Johnson, Edwards) 352
**President's Page** (Fox)
Mandatory CME 53
The Illinois Voluntary Effort 105
N.H.I. Drive Hits Snag 160
Interim Session To Focus on Key Issues 177
Disapprove Concept, Not Method 375
Speak Up 447
Puljic, Smiljan, *jt. author,* Scrotal Hernia Associated with Carcinoma of the Colon (Miller, Gordimer) 405
**Pulse of the ISMS Auxiliary** 12, 96, 172, 198, 383

## R

Rape: A Community Hospital Study (Poma, Stepto) 25
Reaching to the Community Physician, The University Medical School **(SPECIAL ARTICLE)** (Byyny, Gunzburger, Kimball, Siegler, Tarlov) 81
**Reference Issue** 203
**Rheumatology Rounds** (L. F. Layfer and J. V. Jones, *Contributing Co-Editors*)
Painful Anterior Shoulder Mass With Calcification 22
Acute Unilateral Ankle Swelling With Fever 320

## S

Samaraweera, Mohin T., *jt. author,* Carcinoma Arising In a Thyroglossal Duct Cyst (Cacioppo) 79
Scanlon, Patrick J., *Contributing Co-Editor,* **(EKG OF THE MONTH)**
Screening For Alcoholism (Spalt) 348
Scrotal Hernia Associated with Carcinoma of the Colon (Miller, Puljic, Gordimer) 405
Seeler, Ruth Andrea, *Contributing Editor* **(PEDIATRIC PERPLEXITIES)**
**Seminars In Immunopathology and Oncology,** Richard J. Ablin, Ph.D., *Contributing Editor*
Immune Complexes and Human Disease (Andrews, Penny) 85, 146, 366
Services, ISMS **(REFERENCE ISSUE)** 247
Siegler, Mark, *jt. author,* The University Medical School Reaching to the Community Physician **(SPECIAL ARTICLE)** (Byyny, Gunzburger, Kimball, Tarlov) 81
Spalt, Lee, Screening for Alcoholism, 348
Speak Up **(PRESIDENT'S PAGE)** (Fox) 447
Spontaneous Pneumopericardium **(CASE REPORT)** (Lansford, Cooley) 407
Sriram, Krishnan, *jt. author,* Bedside Barium Enema: A New Approach (Balderman, Michel) 29
State of Illinois, Government and Agencies **(REFERENCE ISSUE)** 263
Stepto, Robert C., *jt. author,* Rape: A Community Hospital Study (Poma) 25
Stoker, Jerome M., *jt. author,* Non-Cardiac Creatine Phosphokinase Activity Elevation (Damergis) 138
Student Business Session, 338
Sudden Paraplegia Caused By An Intraspinal Schwannoma (Mansfield) 356
Summary of Actions, 1978 Interim Session House of Delegates 413
**Surgical Grand Rounds,** John M. Beal, *Contributing Editor*
Case Report: Coronary Artery Surgery 36
Computerized Whole Body Tomography 90
Case Report: Cryptorchidism 143
Case Report: Torsion of the Testes 317
Case Report: Branchial Cleft Cyst 361

## T

Tarlov, Alvin R., *jt. author,* The University Medical School Reaching to the Community Physician **(SPECIAL ARTICLE)** (Byyny Gunzburger, Kimball, Siegler) 81
Thyroglossal Duct Cyst, Carcinoma Arising In A (Cacioppo, Samaraweera) 79
Tobin, John R., *Contributing Co-Editor* **(EKG OF THE MONTH)**
Tomography, Computerized Whole Body **(SURGICAL GRAND ROUNDS)** John M. Beal, *Contributing Editor* 90
Torsion of the Testes, Case Report **(SURGICAL GRAND ROUNDS)** John M. Beal, *Contributing Editor* 317
Transfusion Reaction, Delayed Hemolytic, (Lee) 135

## U

Unilateral Ankle Swelling With Fever, Acute **(RHEUMATOLOGY ROUNDS)** L. F. Layfer and J. V. Jones, *Contributing Co-Editors* 320
University Medical School Reaching to the Community Physician, The **(SPECIAL ARTICLE)** (Byyny, Gunzburger, Kimball, Siegler, Tarlov) 81

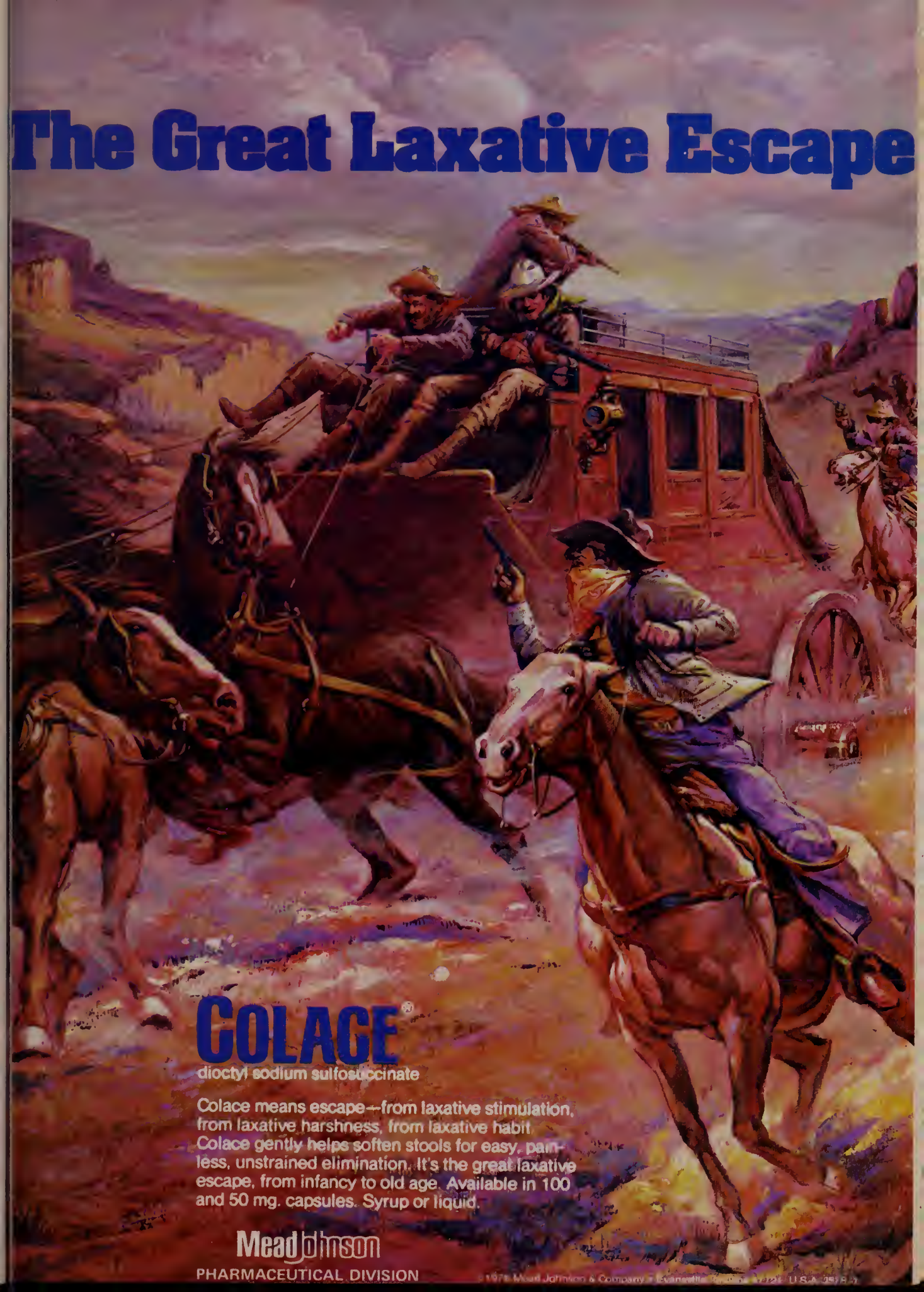
## V

**Viewbox** 67, 129, 185, 391
Voluntary Effort, The Illinois **(PRESIDENT'S PAGE)** (Fox) 105

## Z

Zurbruugg, E., *jt. author,* The Comprehensive Program For Children With Epilepsy **(SPECIAL ARTICLE)** (Hermann, Page-El, Chhabria, Black) 140

# The Great Laxative Escape



## COLACE®

dioctyl sodium sulfosuccinate

Colace means escape—from laxative stimulation, from laxative harshness, from laxative habit. Colace gently helps soften stools for easy, painless, unstrained elimination. It's the great laxative escape, from infancy to old age. Available in 100 and 50 mg. capsules. Syrup or liquid.

Mead Johnson

PHARMACEUTICAL DIVISION

©1975 Mead Johnson & Company • Evansville, Indiana 47721 U.S.A. 3518-4




# Does it influence your choice of a peripheral/cerebral vasodilator*?

- Vasodilan—compatible with coexisting diseases
- Vasodilan—compatible with concomitant therapy
- Vasodilan—compatible with your total regimen for vascular insufficiency

*Indications: Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows:

Possibly Effective:

1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.

Final classification of the less-than-effective indications requires further investigation.

**Composition:** Vasodilan tablets, isoxsuprine HCl, 10 mg and 20 mg

Vasodilan injection, isoxsuprine HCl, 5 mg., per ml.

**Dosage and Administration:** Oral. 10 to 20 mg., three or four times daily.

Intramuscular. 5 to 10 mg (1 or 2 ml.) two or three times daily. Intramuscular administration may be used initially in severe or acute conditions.

**Contraindications and Cautions:** There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

Parenteral administration is not recommended in the presence of hypotension or tachycardia.

Intravenous administration should not be given because of increased likelihood of side effects.

**Adverse Reactions:** On rare occasions oral administration of the drug has been associated in time with the occurrence of hypotension, tachycardia, nausea, vomiting, dizziness, abdominal distress, and severe rash. If rash appears the drug should be discontinued.

Although available evidence suggests a temporal association of these reactions with isoxsuprine, a causal relationship can be neither confirmed nor refuted.

Administration of single dose of 10 mg intramuscularly may result in hypotension and tachycardia. These symptoms are more pronounced in higher doses. For these reasons single intramuscular doses exceeding 10 mg. are not recommended. Repeated administration of 5 to 10 mg intramuscularly at suitable intervals may be employed.

**Supplied:** Tablets, 10 mg., bottles of 100, 1000, 5000 and Unit Dose; Tablets, 20 mg., bottles of 100, 500, 1000, 5000 and Unit Dose; Injection, 10 mg per 2 ml. ampul, box of six 2 ml. ampuls

U.S. Pat No. 3,056,836

# VASODILAN®

## (ISOXSUPRINE HCl)

**20-mg tablets**

Mead Johnson PHARMACEUTICAL DIVISION

# ISMS Guide to Continuing Medical Education

Compiled for Illinois physicians by the
ILLINOIS COUNCIL ON CONTINUING MEDICAL EDUCATION
55 E. Monroe St., Suite 3510 • Chicago, IL 60603 • (312) 236-6110

*Items for this Calendar must be received 90 days prior to the event. Those received earlier may appear in up to three monthly issues.*

*WARNING! Items for this Calendar come from many sources, often far in advance of the publication date. Sometimes, cancellations or changes in date, place or time occur too late to be corrected before publication. You are urged to contact the sponsoring organization to confirm information given below.*

## JANUARY

### *Family Medicine*

**ETHICAL ISSUES IN CRITICAL CARE**
**For:** GP's. Lecture, Jan. 10, 2:00-5:00 p.m., Chicago. **Sponsor:** The University of Chicago Medical Center, Frontiers of Medicine, 950 E. 59th St., Box 451, Chicago 60637. **Fee:** $20. **Reg. limit:** none. **CME Credit:** AMA Category 1, 3 hours; AAFP Elective, 3 hours. **Contact:** Elaine Ehrman. **Phone:** 312-947-5777.

### *Family Medicine*

**UPDATE—PRIMARY CARE MEDICINE**
**For:** GP's, FP's, Internists. Lectures, Jan. 5 & 26, 8:00 a.m., Chicago. **Sponsor:** Grant Hospital, 550 W. Webster, Chicago 60614. **Fee:** none. **Reg. limit:** none. **CME Credit:** AMA Category 1, 2 hours. **Contact:** P. Colon. **Phone:** 312-883-2112.

### *Family Medicine*

**9TH ANNUAL WINTER REFRESHER COURSE FOR FAMILY PHYSICIANS**
**For:** FP's. 3-day course, Jan. 17-19, Pfister Hotel, Milwaukee, Wisc. **Sponsor:** Department of Family Practice, The Medical College of Wisconsin, 610 North 19th St., Milwaukee, Wisc. 53233. **Cosponsor:** SE Chapter, Wisconsin Academy of Family Physicians. **Reg. deadline:** 1/5. **Fee:** $160. **Reg. limit:** 225. **Credit:** AAFP Prescribed, 21 hours; AMA Category 1, 21 hours. **Contact:** Susanna Rechlitz. **Phone:** 414-933-0700.

### *Family Therapy*

**PERSONAL/PROFESSIONAL GROWTH WORKSHOP FOR THERAPISTS: WITH OR WITHOUT PARTNERS**
**For:** MD's, therapists. Seminar, Jan. 25, 26, 27, Oak Park. **Speaker:** Charles Kramer, MD. **Sponsor:** Center for Family Studies/The Family Institute of Chicago, 10 E. Huron, Chicago 60611. **Cosponsors:** Institute of Psychiatry, Northwestern Memorial Hospital, Northwestern University Medical School. **Reg. limit:** 16. **CME Credit:** AMA Category 1, 17 hours. **Contact:** Wendy Brockington. **Phone:** 312-649-7285.

### *Family Therapy*

**LAW IN THE EVERYDAY PRACTICE OF PSYCHOTHERAPY**
**For:** MD's. Workshop, Jan. 26 & 27, 9:30-4:30 p.m., Chicago. **Speaker:** Sandra Nye, JD, MSW. **Sponsor:** Center for Family Studies/The Family Institute of Chicago, 10 E. Huron, Chicago 60611. **Cosponsors:** Institute of Psychiatry, Northwestern Memorial Hospital, Northwestern University Medical School. **Reg. limit:** 40. **CME Credit:** AMA Category 1, 12 hours. **Contact:** Wendy Brockington. **Phone:** 312-649-7285.

### *OBGYN Pathology*

**UNDERSTANDING OVARIAN CYSTOMAS—HISTOGENESIS & CLINICAL IMPLICATIONS**
**For:** Gynecologists, Pathologists. Lecture, Jan. 5, Chicago. **Speaker:** Ralph Richart, MD. **Sponsor:** Medical Education Dept., St. Joseph Hospital, 2900 No. Lake Shore Dr., Chicago, IL 60657. **Cosponsor:** Clyde J. Geiger, MD, Lectureship Endowment Foundation. **Reg. deadline:** 12/20. **Fee:** none. **Reg. limit:** none. **Credit:** AMA Category 1, 1 hour. **Contact:** Sharon Afable. **Phone:** 312-975-3002.

### *Internal Medicine*

**YEAR IN INTERNAL MEDICINE**
**For:** GP's. 3-day conference, Jan. 24-26, Chicago. **Sponsor:** Northwestern University Medical School, Alumni Center for Continuing Education, 301 E. Chicago Ave., Chicago, IL 60611. **Credit:** AMA Category 1, 21 hours. **Contact:** James Dyson, PhD. **Phone:** 312-649-8533.

### *Internal Medicine*

**RHEUMATIC DISEASES: CURRENT CONCEPTS OF PATHOGENESIS, DIAGNOSIS AND MANAGEMENT**
**For:** Rheumatologists, Internists, FP's. Lecture, Jan. 18, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School, Towsley Center for CME, Ann Arbor, Michigan 48109. **Fee:** $130. **Reg. limit:** 400. **Credit:** AAFP Prescribed, 18 hours; AMA Category 1, 18 hours. **Contact:** Floyd Pennington. **Phone:** 313-764-2287.

### *Medicine*

**14th ANNUAL MEETING**
**For:** FP's. Symposium/workshop, Jan. 14-19, Las Vegas, Nevada. **Speaker:** Michael De Bakey, MD. **Fee:** $250. **Reg. limit:** none. **CME Credit:** AMA Category 1, 40 hours. **Sponsor:** American Society of Contemporary Medicine and Surgery, 6 No. Michigan Ave., Chicago 60602. **Contact:** John Bellows, MD. **Phone:** 312-236-4673.

### *Medicine/Surgery*

**RENAL TRANSPLANTS—COST AND QUALITY OF LIFE VS. DIALYSIS**
**For:** MD's. Lecture, Jan. 17, 1:00 p.m., Good Samaritan Hospital, 3815 Highland Ave., Downers Grove, IL 60515. **Speaker:** Jesse Hano, MD. **Sponsor:** DuPage County Medical Society, 26 W. St. Charles Rd., Lombard, IL 60148. **Reg. limit:** none. **Fee:** none. **Credit:** AAFP Elective, 3 hours; AMA Category 1, 3 hours. **Contact:** Lillian Widmer. **Phone:** 312-495-4050.

### *Medicine/Surgery*

**24th MEDICAL/SURGICAL SEMINAR FOR LAKE COUNTY**
**For:** MD's. Seminar, Jan. 24, 8:00 a.m.-1:15 p.m., Waukegan. **Sponsor:** St. Therese Hospital, 2615 Washington, Waukegan, IL 60085. **Fee:** $2.50. **Reg. limit:** none. **Reg. deadline:** Jan. 19. **Credit:** AAFP Elective, 5 hours; AMA Category 1, 5 hours. **Contact:** R. M. Adelman, MD. **Phone:** 312-688-5800.

### *Ophthalmology*

**14th ANNUAL SCIENTIFIC ASSEMBLY**
**For:** Ophthalmologists. Seminars/lectures/workshops, Jan. 14-19, Las Vegas, Nevada. **Sponsor:** American Society of Contemporary Ophthalmology, 6 No. Michigan Ave., Chicago 60602. **Fee:** $250. **Reg. limit:** none. **CME Credit:** AMA Category 1, 40 hours. **Contact:** John Bellows, MD. **Phone:** 312-236-4673.

### *Ophthalmology*

**THE ROLE OF THE PRIMARY PHYSICIAN IN EYE CARE**
**For:** FP's, Internists, Pediatricians. Workshop, 3 sessions in 1979, Chicago. **Sponsor:** Dept. of Ophthalmology, University of Illinois, 1855 W. Taylor, Chicago 60612. **Fee:** $200/session. **Reg. limit:** 40. **CME Credit:** AMA Category 1. **Contact:** Carmen Carrasco. **Phone:** 312-996-8023.

### *Pediatrics*

**MIDWEST CONFERENCE ON TRANSCUTANEOUS $PO_2$ MONITORING IN THE NEWBORN INFANT**
**For:** Pediatricians, Anesthesiologists, Resp. Therapists. 2-day conference, Jan. 18-19, Water Tower Hyatt House, Chicago. **Sponsor:** University of Illinois College of Medicine, Dept. of Pediatrics, Office of Continuing Education Services, 1853 W. Polk St., Room 144, Chicago, IL 60612. **Fee:** $125; $75, residents, interns, students. **Reg. limit:** 250. **Credit:** AMA Category 1, 13 hours. **Contact:** Sue Korienek. **Phone:** 312-996-8025.

### *Psychiatry/Psychology*

**NARCISSISTIC FACTORS IN PSYCHOTHERAPY**
**For:** MD's, Psychiatrists. Lecture, Jan. 17, 1:00-4:00 p.m., Forest Park. **Speaker:** Arnold Goldberg, MD. **Sponsor:** Riveredge Hospital Foundation, 8311 W. Roosevelt Rd., Forest Park 60130. **Fee:** $15. **CME Credit:** AMA Category 1, 3 hours. **Contact:** Susan Cosgrove. **Phone:** 312-771-7000.

## FEBRUARY

### *Anesthesiology*

**REGIONAL ANESTHESIA**
**For:** Anesthesiologists. 5-day lecture, Feb. 26, Chicago. **Speaker:** Vincent Collins, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 South Wood St., Chicago, IL 60612. **Fee:** $325. **Reg. limit:** 10. **Credit:** AMA Category 1, 40 hours. **Contact:** Robert Baker, MD. **Phone:** 312-733-2800.

### *Ear, Nose and Throat*

**COMMON EAR, NOSE AND THROAT PROBLEMS**
**For:** GP's. Lecture, Feb. 14, 1:30-4:45 p.m., Chicago. **Sponsor:** The University of Chicago Medical Center, Frontiers of Medicine, 950 E. 59th St., Box 451, Chicago, IL 60637. **Fee:** $20. **Reg. limit:** none. **Credit:** AAFP Elective, 3 hours; AMA Category 1, 3 hours. **Contact:** Mrs. Elaine Ehrman. **Phone:** 312-947-5777.

### *Emergency Care*

**EMERGENCY MEDICINE**
**For:** FP's, Emergency MD's. Lecture/workshop, Feb. 19-23, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School, Towsley Center for CME, Ann Arbor, Michigan 48109. **Cosponsor:** American College of Emergency Physicians, Michigan Affiliate. **Fee:** $275. **Reg. limit:** 500. **Credit:** AAFP Prescribed, 35 hours; AMA Category 1, 35 hours. **Contact:** Floyd Pennington. **Phone:** 313-764-2287.

### *Family Medicine*

**UPDATE—PRIMARY CARE MEDICINE**
**For:** GP's, FP's, Internists. Lectures, Feb. 2, 16, 23, 8:00 a.m., Chicago. **Sponsor:** Grant Hospital, 550 W. Webster, Chicago, IL 60614. **Fee:** none. **Reg. limit:** none. **Credit:** AMA Category 1, 3 hours. **Contact:** Ms. P. Colon. **Phone:** 312-883-2112.

### *Family Medicine*

**CLINICAL MEDICINE UPDATE**
**For:** GP's, FP's. 5-day lecture, Feb. 19, Chicago. **Speaker:** Sheldon Waldstein, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 South Wood St., Chicago, IL 60612. **Fee:** $225. **Reg. limit:** 100. **Credit:** AMA Category 1, 40 hours. **Contact:** Robert Baker, MD. **Phone:** 312-733-2800.

### *Family Therapy*

**THE THERAPIST'S OWN FAMILY**
**For:** Therapists. Lecture series, Feb.-June, 9:00-1:00 p.m., Oak Park. **Speaker:** Jeannette Kramer. **Sponsor:** Center for Family Studies/Family Institute of Chicago, 10 E. Huron, Chicago, IL 60611. **Cosponsor:** Institute of Psychiatry, Northwestern Memorial Hospital, Northwestern University Medical School. **Fee:** $150. **Reg. limit:** none. **Credit:** AMA Category 1, 20 hours. **Contact:** Wendy Brockington. **Phone:** 312-649-7285.

### *Family Therapy*

**FAMILY SYSTEMS ASSESSMENT—INTRODUCTORY COURSE**
**For:** Therapists. Course, Feb. 5-9, Chicago. **Sponsor:** Center for Family Studies/Family Institute of Chicago, 10 E. Huron, Chicago, IL 60611. **Cosponsor:** Institute of Psychiatry, Northwestern Memorial Hospital, Northwestern University Medical School. **Fee:** $155. **Credit:** AMA Category 1, 27.5 hours. **Contact:** Wendy Brockington. **Phone:** 312-649-7285.

*Family Therapy*

**INTEGRATION OF CULTURAL HISTORY INTO ASSESSMENT AND INTERVENTION**
**For:** Therapists. 3-day conference, Feb. 22-24, Chicago. **Speakers:** George Vassiliou, MD., Vasso Vassiliou, PhD. **Sponsor:** Center for Family Studies/Family Institute of Chicago, 10 E. Huron St., Chicago, IL 60611. **Cosponsors:** Institute of Psychiatry, Northwestern Memorial Hospital, Northwestern University Medical School. **Fee:** $120. **Credit:** AMA Category 1, 18 hours. **Contact:** Wendy Brockington. **Phone:** 312-649-7285.

*Family Therapy*

**STRATEGIES AND TECHNIQUES—INTERMEDIATE COURSE**
**For:** Therapists. Course, Feb. 12-16, Chicago. **Sponsor:** Center for Family Studies/Family Institute of Chicago, 10 E. Huron, Chicago, IL 60611. **Cosponsor:** Institute of Psychiatry, Northwestern Memorial Hospital, Northwestern University Medical School. **Credit:** AMA Category 1, 27.5 hours. **Contact:** Wendy Brockington. **Phone:** 312-649-7285.

*Forensic Medicine*

**REVIEW OF CURRENT FORENSIC PATHOLOGY CASES**
**For:** MD's, DDS's, LIB's. Lecture/workshop, Thursdays, 2:00 p.m., Chicago. **Sponsor:** Office of the Medical Examiner, Cook County, IL, 1828 West Polk St., Chicago, IL 60612. **Fee:** none. **Reg. limit:** 50. **Contact:** Robert Stein, MD. **Phone:** 312-443-5017.

*Internal Medicine*

**USE OF THE LABORATORY IN CLINICAL PRACTICE**
**For:** Internists, FP's, GP's. Symposium, Feb. 22-23, St. Louis, Missouri. **Sponsor:** Office of CME, Washington University School of Medicine, Box 8063, 660 So. Euclid, St. Louis, Missouri 63110. **Fee:** $120. **Reg. limit:** 150. **Credit:** AAFP Elective, 12 hours; AMA Category 1, 12 hours. **Contact:** Loretta Giacoletto. **Phone:** 314-454-3873.

*Internal Medicine*

**TB TODAY**
**For:** Internists, FP's, GP's. Symposium, Feb. 15-16, St. Louis, Missouri. **Sponsor:** Office of CME, Washington University School of Medicine, Box 8063, 660 So. Euclid, St. Louis, Missouri 63110. **Fee:** $120. **Reg. limit:** 150. **Credit:** AAFP Elective, 12 hours; AMA Category 1, 12 hours. **Contact:** Loretta Giacoletto. **Phone:** 314-454-3873.

*Medicine*

**5th ANNUAL INTERNAL MEDICINE SYMPOSIUM**
**For:** MD's, office staff. Symposium, Feb. 9-10, Springfield. **Sponsor:** SIU School of Medicine, 801 No. Rutledge, P.O. Box 3926, Springfield, IL 62708. **Reg. limit:** none. **Credit:** AMA Category 1, 10 hours. **Contact:** Lorraine Stephenson. **Phone:** 217-782-7711.

*Neurology*

**NEUROLOGY, PART I, BASIC**
**For:** Neurologists, Psychiatrists. 5½-day Lecture, Feb. 26, Chicago. **Speaker:** Neil Allen, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 So. Wood St., Chicago, IL 60612. **Fee:** $250. **Reg. limit:** 150. **Credit:** AMA Category 1, 44 hours. **Contact:** Robert Baker, MD. **Phone:** 312-733-2800.

*Pediatrics*

**DETECTION, MANAGEMENT OF CHILD ABUSE**
**For:** MD's, office staff. Symposium, Feb. 14, 9:00 a.m.-12:00 noon, Centreville. **Sponsor:** SIU School of Medicine, 801 No. Rutledge, P.O. Box 3926, Springfield, IL 62708. **Credit:** AMA Category 1, 3 hours. **Contact:** Lorraine Stephenson. **Phone:** 217-782-7711.

*Psychiatry*

**TOPICS IN PSYCHOSOMATIC AND BEHAVIORAL MEDICINE**
**For:** Psychiatrists, primary care physicians. Lecture, Feb. 27-28, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School, Towsley Center for CME Ann Arbor, Michigan 48109. **Fee:** $120. **Reg. limit:** 350. **Credit:** AAFP Prescribed, 14 hours; AMA Category 1, 14 hours. **Contact:** Floyd Pennington. **Phone:** 313-764-2287.

*Psychiatry*

**SYSTEMS AND STRATEGIES IN FAMILY THERAPY**
**For:** Psychiatrists. Lecture, Feb. 21, 1:00-4:00 p.m., Forest Park. **Speaker:** Peggy Papp, ACSW. **Sponsor:** Riveredge Hospital Foundation, 8311 W. Roosevelt Road, Forest Park, IL 60130. **Fee:** $15. **Credit:** AMA Category 1, 3 hours. **Contact:** Susan Cosgrove. **Phone:** 312-771-7000.

*Surgery*

**SPECIALTY REVIEW COURSE IN THORACIC SURGERY**
**For:** General and Cardiothoracic Surgeons. 6-day lecture, Feb. 13, Chicago. **Speaker:** Sidney Levitsky, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 So. Wood St., Chicago, IL 60612. **Fee:** $250. **Reg. limit:** 200. **Credit:** AMA Category 1, 48 hours. **Contact:** Robert Baker, MD. **Phone:** 312-733-2800.

*Surgery*

**SPECIAL REVIEW COURSE IN NEUROLOGICAL SURGERY**
**For:** Neurosurgeons, Neurologists. 10-day lecture, Feb. 2, Chicago. **Speaker:** Leonard Kranzler, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 So. Wood St., Chicago, IL 60612. **Fee:** $425. **Reg. limit:** 250. **Credit:** AMA Category 1, 104 hours. **Contact:** Robert Baker, MD. **Phone:** 312-733-2800.

# *MARCH*

*Family Therapy*

**SIXTH ANNUAL SPRING CONFERENCE: TREATMENT OF MARITAL COUPLES**
**For:** Psychiatrists, Therapists. 2-day conference, March 30-31, Continental Plaza Hotel, Chicago. **Speaker:** Clifford Sager, MD. **Sponsor:** Center for Family Studies/Family Institute of Chicago, 10 E. Huron St., Chicago, IL 60611. **Cosponsors:** Institute of Psychiatry, Northwestern Memorial Hospital, Northwestern University Medical School. **Credit:** AMA Category 1, 12 hours. **Contact:** Wendy Brockington. **Phone:** 312-649-7285.

*Gastroenterology*

**NEW DEVELOPMENTS IN INFLAMMATORY BOWEL DISEASE**
**For:** GP's. Lecture, March 14, 1:30-5:00 p.m., Chicago. **Sponsor:** The University of Chicago Medical Center, Frontiers of Medicine, 950 E. 59th St., Box 451, Chicago, IL 60637. **Fee:** $20. **Reg. limit:** none. **Credit:** AAFP Elective, 3 hours; AMA Category 1, 3 hours. **Contact:** Elaine Ehrman. **Phone:** 312-947-5777.

*Hematology*

**HEMATOLOGY REVIEW**
**For:** Hematologists, Medical Technicians. Lecture/Lab., March 6-9, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School, Towsley Center for Continuing Medical Education, Ann Arbor, Michigan 48109. **Fee:** $225, MD; $175, Techs. **Reg. limit:** 325. **Credit:** AMA Category 1, 28 hours; AAFP Elective, 28 hours. **Contact:** Floyd Pennington. **Phone:** 313-764-2287.

*Internal Medicine*

**INTERNAL MEDICINE BOARD EXAMINATION REVIEW**
**For:** MD's. Weekly lectures, March-May, Monday evenings, St. Louis, Missouri. **Sponsor:** Continuing Medical Education, Washington University School of Medicine, Box 8063, 660 So. Euclid, St. Louis, Missouri 63110. **Fee:** $120. **Reg. limit:** 175. **Credit:** AAFP Elective, 36 hours; AMA Category 1, 36 hours. **Contact:** Loretta Giacoletto. **Phone:** 314-454-3873.

*Internal Medicine*

**A DAY OF CLINICAL GASTROENTEROLOGY**
**For:** FP's, Internists. Lecture, March 24, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School, Towsley Center for Continuing Medical Education, Ann Arbor, Michigan 48109. **Fee:** $70. **Reg. limit:** 350. **Credit:** AMA Category 1, 7 hours; AAFP Elective, 7 hours. **Contact:** Floyd Pennington. **Phone:** 313-764-2287.

*Internal Medicine*

**AN UPDATE IN RENAL DISEASES**
**For:** MD's. Symposium, March 1-2, St. Louis, Missouri. **Sponsor:** Washington University School of Medicine, Continuing Medical Education, Box 8063, 660 So. Euclid, St. Louis, Missouri 63110. **Fee:** $120. **Reg. limit:** 150. **Credit:** AAFP Elective, 12 hours; AMA Category 1, 12 hours. **Contact:** Loretta Giacoletto. **Phone:** 314-454-3873.

*Occupational Health*

**WELLNESS IN THE WORK PLACE—PREVENTIVE MEDICINE**
**For:** MD's, nurses. Seminar, March 9-10, Water Tower Hyatt House, Chicago. **Sponsor:** Central States Occupational Medical Association, 119 Shabbona Dr., Park Forest, IL 60466. **Cosponsor:** American Occupational Medical Association. **Fee:** $30. **Reg. limit:** none. **Credit:** AAFP Elective, 9 hours; AMA Category 1, 9 hours. **Contact:** Rita Packer. **Phone:** 312-747-8124.

*Pediatric Urology*

**PEDIATRIC UROLOGY**
**For:** Urologists, Pediatricians. Seminar, March 9-10, Chicago. **Sponsor:** American Urological Association, P.O. Box 1129, Aspen, Colorado 81611. **Fee:** $200, AUA; $250, non-AUA. **Reg. limit:** 300. **Credit:** AMA Category 1, 16 hours. **Contact:** Jean Greiner. **Phone:** 303-925-2018.

*Pediatrics*

**ADVANCES IN PEDIATRICS**
**For:** Pediatricians. Lecture, March 14-16, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School, Towsley Center for Continuing Medical Education, Ann Arbor, Michigan 48109. **Fee:** $180. **Reg. limit:** 350. **Credit:** AAFP Prescribed, 21 hours; AMA Category 1, 21 hours. **Contact:** Floyd Pennington. **Phone:** 313-764-2287.

*Surgery*

**GENERAL SURGERY CONFERENCE**
**For:** Surgeons. Lecture, March 22-23, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School, Towsley Center for Continuing Medical Education, Ann Arbor, Michigan 48109. **Fee:** $140. **Reg. limit:** 250. **Credit:** AAFP Elective, 14 hours; AMA Category 1, 14 hours. **Contact:** Floyd Pennington. **Phone:** 313-764-2287.

## INCREASE IN CME ACCREDITATION FEES

**Due to rising administrative costs, the ISMS Board of Trustees has approved a new fee structure for Illinois CME sponsors seeking accreditation status. The following fees are effective as of January 1, 1979:**

| | |
|---|---|
| **Registration fee (waived for ISMS component societies)** | **$100** |
| **Accreditation survey fee for medical organizations with 49 or fewer members** | **$300** |
| **All other CME sponsors** | **$450** |

## MEDICINE FOR TODAY

***Winter Sessions***

**For: Family Practitioners (emphasis on Cardiology, Gynecology, Endrocrinology, Pulmonary). 30th Annual Postgraduate Program of the Illinois Academy of Family Physicians. CME Credit: AMA Category 1, 30 hours; AAFP Prescribed, 30 hours. Fee: $100, members; $110, non-members. Schedule includes:**

***Belleville*—Feb. 22; Mar. 1, 8, 15, 22, 29**
***Berwyn*—Feb. 21, 28; Mar. 7, 21, 28; Apr. 4**
***Beverly*—Feb. 21, 28; Mar. 7, 21, 28; Apr. 4**
***Centralia*—Feb. 21; Mar. 7, 21**
***Champaign*—Mar. 1, 15, 29**
***Chicago Nearwest*—Feb. 21, 28; Mar. 7, 21, 28; Apr. 4**
***Chicago North*—Feb. 21, 28; Mar. 7, 21, 28; Apr. 4**
***Chicago Southwest*—Feb. 21, 28; Mar. 7, 21, 28; Apr. 4**
***Harvey*—Feb. 21, 28; Mar. 7, 21, 28; Apr. 4**
***Hinsdale*—Feb. 21; Mar. 7, 21**
***Melrose Park*—Feb. 21, 28; Mar. 7, 21, 28; Apr. 4**
***Park Ridge*—Feb. 21, 28; Mar. 7, 21, 28; Apr. 4**
***Peoria*—Feb. 22; Mar. 8, 22**
***Rockford*—Mar. 1, 15, 29**
***Rock Island*—Feb. 22; Mar. 8, 22**
***Springfield*—Mar. 1, 29**

**For complete information, contact: Illinois Academy of Family Physicians, 1200 Harger Road, Suite 405, Oak Brook, Illinois 60521. Phone: 312-325-8502.**

# Angina freedom fighter...




**Burroughs Wellcome Co.**
Research Triangle Park
North Carolina 27709

Wellcome

**Cardilate® (erythrityl tetranitrate)**
INDICATIONS: For the prophylaxis and long-term treatment of patients with frequent or recurrent anginal pain and reduced exercise tolerance associated with angina pectoris, rather than for the treatment of the acute attack of angina pectoris, since its onset is somewhat slower than that of nitroglycerin.

PRECAUTIONS: As with other effective nitrites, some fall in blood pressure may occur with large doses.

Caution should be observed in administering the drug to patients with a history of recent cerebral hemorrhage, because of the vasodilation which occurs in the area. Although therapy permits more normal activity, the patient should not be allowed to misinterpret freedom from anginal attacks as a signal to drop all restrictions.

SIDE EFFECTS: No serious side effects have been reported. In sublingual therapy, a tingling sensation (like that of nitroglycerin) may sometimes be noted at the point of tablet contact with the mucous membrane. If objectionable, this may be mitigated by placing the tablet in the buccal pouch. As with nitroglycerin or other effective nitrates, temporary vascular headache may occur during the first few days of therapy. This can be controlled by temporary dosage reduction in order to allow adjustments of the cerebral hemodynamics to the initial marked cerebral vasodilation. These headaches usually disappear within one week of continuous therapy but may be minimized by the administration of analgesics.

Mild gastrointestinal disturbances occur occasionally with larger doses and may be controlled by reducing the dose temporarily.

DOSAGE: Therapy may be initiated with 10 mg sublingually prior to each anticipated physical or emotional stress and at bedtime for patients subject to nocturnal attacks. The dose may be increased or decreased as needed.

HOW SUPPLIED: 10 mg chewable scored tablets, bottle of 100. Also 5, 10 and 15 mg oral/sublingual scored tablets in bottles of 100. 10 mg oral/ sublingual scored tablets also supplied in bottle of 1,000.

Also available: Cardilate®-P (Erythrityl Tetranitrate with Phenobarbital)* Tablets (Scored).

(*Warning—may be habit-forming.)

1. Taken sublingually, Cardilate® (erythrityl tetranitrate) begins to work within 5 minutes, eliminating or reducing frequency and severity of anginal pain for up to two hours.
2. Fear of pain, a major deterrent to achieving acceptable (and desirable) levels of activity, including sex, may be allayed with Cardilate. Effective prophylaxis and improved exercise tolerance help toward normalizing the lives of anginal patients.

# Cardilate®
## (erythrityl tetranitrate)




Copyright ©1978, Schering Corporation. All rights reserved

Schering

## A unique clinical option... from Schering allergy research

# Optimine® 1 mg. tablets

brand of

# azatadine maleate

## Long-acting antihistamine relief

B.I.D.dosage provides sustained symptomatic relief for up to 24 hours. Helps to keep patients adequately controlled

Prolonged duration of antihistamine action is inherent in the molecular structure...not due to tablet coatings or other slow release processes

## B.I.D. effectiveness

Patients can fit OPTIMINE into morning and evening routines...no need to carry medication. The easy-to-titrate, scored 1 mg. tablet permits dosage flexibility to meet individual patient requirements

## No dyes

Contains no sensitizing dyes with their potential for causing allergic reactions

**Optimine** A practical antihistamine to help allergy patients stay on therapy

**CONTRAINDICATIONS** Use in Newborn or Premature infants. This drug should not be used in newborn or premature infants.

Use in Nursing Mothers. Because of the higher risk of antihistamines for infants generally and for newborns and prematures in particular, antihistamine therapy is contraindicated in nursing mothers.

Use in Lower Respiratory Disease. Antihistamines should NOT be used to treat lower respiratory tract symptoms including asthma

Antihistamines are also contraindicated in the following conditions: hypersensitivity to azatadine maleate and other antihistamines of similar chemical structure; monoamine oxidase inhibitor therapy (See DRUG INTERACTIONS Section).

**WARNINGS** Antihistamines should be used with considerable caution in patients with narrow angle glaucoma, stenosing peptic ulcer, pyloroduodenal obstruction, symptomatic prostatic hypertrophy; bladder neck obstruction.

Use in Children: In infants and children especially, antihistamines in overdosage may cause hallucinations, convulsions, or death.

As in adults, antihistamines may diminish mental alertness in children. In the young child, particularly, they may produce excitation.

OPTIMINE TABLETS ARE NOT INTENDED FOR USE IN CHILDREN UNDER 12 YEARS OF AGE.

Use in Pregnancy: Experience with this drug in pregnant women is inadequate to determine whether there exists a potential for harm to the developing fetus

Use with CNS Depressants. Azatadine maleate has additive effects with alcohol and other CNS depressants (hypnotics, sedatives, tranquilizers, etc.).

Use in Activities Requiring Mental Alertness. Patients should be warned about engaging in activities requiring mental alertness, such as driving a car or operating appliances, machinery, etc

Use in the Elderly (approximately 60 years or older): Antihistamines are more likely to cause dizziness, sedation, and hypotension in elderly patients.

**PRECAUTIONS** Azatadine maleate has an atropine-like action and, therefore, should be used with caution in patients with a history of bronchial asthma, increased intraocular pressure; hyperthyroidism, cardiovascular disease, hypertension

**DRUG INTERACTIONS** MAO inhibitors prolong and intensify the anticholinergic (drying) effects of antihistamines

**ADVERSE REACTIONS** The most frequent adverse reactions are underlined:

*General:* Urticaria, drug rash, anaphylactic shock, photosensitivity, excessive perspiration, chills, dryness of mouth, nose, and throat

*Cardiovascular System:* Hypotension, headache, palpitations, tachycardia, extrasystoles

*Hematologic System:* Hemolytic anemia, thrombocytopenia, agranulocytosis

*Nervous System:* Sedation, sleepiness, dizziness, disturbed coordination, fatigue, confusion, restlessness, excitation, nervousness, tremor, irritability, insomnia, euphoria, paresthesias, blurred vision, diplopia, vertigo, tinnitus, acute labyrinthitis, hysteria, neuritis, convulsions.

*Gastrointestinal System:* Epigastric distress, anorexia, nausea, vomiting, diarrhea, constipation

*Genitourinary System:* Urinary frequency, difficult urination, urinary retention, early menses

*Respiratory System:* Thickening of bronchial secretions, tightness of chest and wheezing, nasal stuffiness.

**OVERDOSAGE** Antihistamine overdosage reactions may vary from central nervous system depression to stimulation. Stimulation is particularly likely in children. Atropine-like signs and symptoms (dry mouth; fixed, dilated pupils; flushing, and gastrointestinal symptoms) may also occur.

If vomiting has not occurred spontaneously, the patient should be induced to vomit. This is best done by having him drink a glass of water or milk after which he should be made to gag. Precautions against aspiration must be taken, especially in infants and children.

If vomiting is unsuccessful, gastric lavage is indicated within three hours after ingestion and even later if large amounts of milk or cream were given beforehand. Isotonic and ½ isotonic saline is the lavage solution of choice

Saline cathartics, such as milk of magnesia, draw water into the bowel by osmosis and therefore are valuable for their action in rapid dilution of bowel content.

Stimulants should not be used.

Vasopressors may be used to treat hypotension

FEBRUARY 1977 11055010

For more complete details, consult package insert or Schering literature available from your Schering Representative of Professional Services Department, Schering Corporation, Kenilworth, New Jersey 07033.

Schering

Schering Corporation
Kenilworth, New Jersey 07033

8202-0000R

# Physician Recruitment Program

*In an effort to reduce the number of towns in Illinois needing physicians, the Physician Recruitment Program and the Doctor's Job Fair, are publishing synopses in the Journal.*

*Physicians who are seeking a place to practice or who know of any out-of-state physicians seeking an Illinois residence are asked to notify the Program.*

*Any areas wishing to be listed should contact: Mrs. E. Duffy, Physician Recruitment Program, ISMS, 55 E. Monroe, Suite 3510, Chicago, 60603.*

**ARCOLA:** Wanted-American trained F.P. to join established F.P. in active practice. Must do some O.B. Guaranteed salary and benefits. Eventual partnership. Robert N. Arrol, M.D., 126 S. Locust, Arcola, 61910. (217) 268-4444, or 268-4404. (12)

**ATKINSON:** Due to recent death of town's physician, a modern clinic with all facilities is available to a family physician who wants security and a wonderful place to practice. Hammond Henry Hospital only 8 miles away. Excellent grade and high schools and near Black Hawk Junior College. 30 miles to Quad City area, 140 miles to Chicago and 60 miles from Peoria. All recreational facilities nearby. CONTACT: John W. Ellis, Mayor, Atkinson 61235. (309) 936-7566. (12)

**AURORA:** Opening in General Internal Medicine with 40 man group. Complete office facilities. Good starting salary. Contact: L. E. Snyder, M.D., 1870 W. Galena Blvd., Aurora 60506. (312-859-6700) (1)

**CARBONDALE:** G.P., F.P., or Internist for health service at prominent university which includes a school of medicine. Scenic recreational area combining the virtues of small town living with the cultural and shopping assets of a large metropolitan area. Attractive salary, 40 hour work week and generous fringe benefits. IL license required. A.A./E.O.E. For further information send vitae to Don Knapp, M.D., Medical Director, SIU-C Health Service, Carbondale, IL 62901. (3)

**CHICAGO:** Major Chicago based retailer seeking corporate physician. Up-to-date, modern facilities, regular hours and comprehensive employee benefits make this a very desirable position. Please send resume with salary requirements. Contact: Professional Employment Director, Sears, Roebuck & Co., D/707-2, Chicago 60684 (1)

**FAIRFIELD:** Population 6,500. Opening for OB-Gyn board eligible or certified and general practitioner to join group of two physicans (F.P. and surgeon). Complete office facilities, excellent salary and fringe benefits, opportunity to become full partner. Near university, junior college locally. Good fishing, hunting, cultural opportunities, all churches. Contact: S. W. Konarski, M.D., 401 East Center Street, Fairfield 62837. (618) 842-2187. (3)

**HARVARD:** An internist, OB-GYN for Northern Illinois commuter suburb. New hospital, good schools, guaranteed salary and benefits based on qualifications. Close to resort areas. A solid community economically. Contact: Dr. John P. Hill, 502 N. Hart, Harvard 60033. (815-943-5151) (1)

**LA GRANGE:** Western suburb of Chicago, medium sized hospital. Opening for Director of medical affairs, new position, full time. Work with medical staff on CME, medical staff affairs, Family Practice Residency Program and University affiliation. Contact, Administrator, 312-352-1200. (2)

**LISLE:** Physician needed to assist me in handling my very extensive private family practice. Salary open, good opportunity for this relationship to merge into a partnership association. CONTACT: M. Sinkovits, 4513 Lincoln Ave., Lisle 60532. (312) 968-2735. (12)

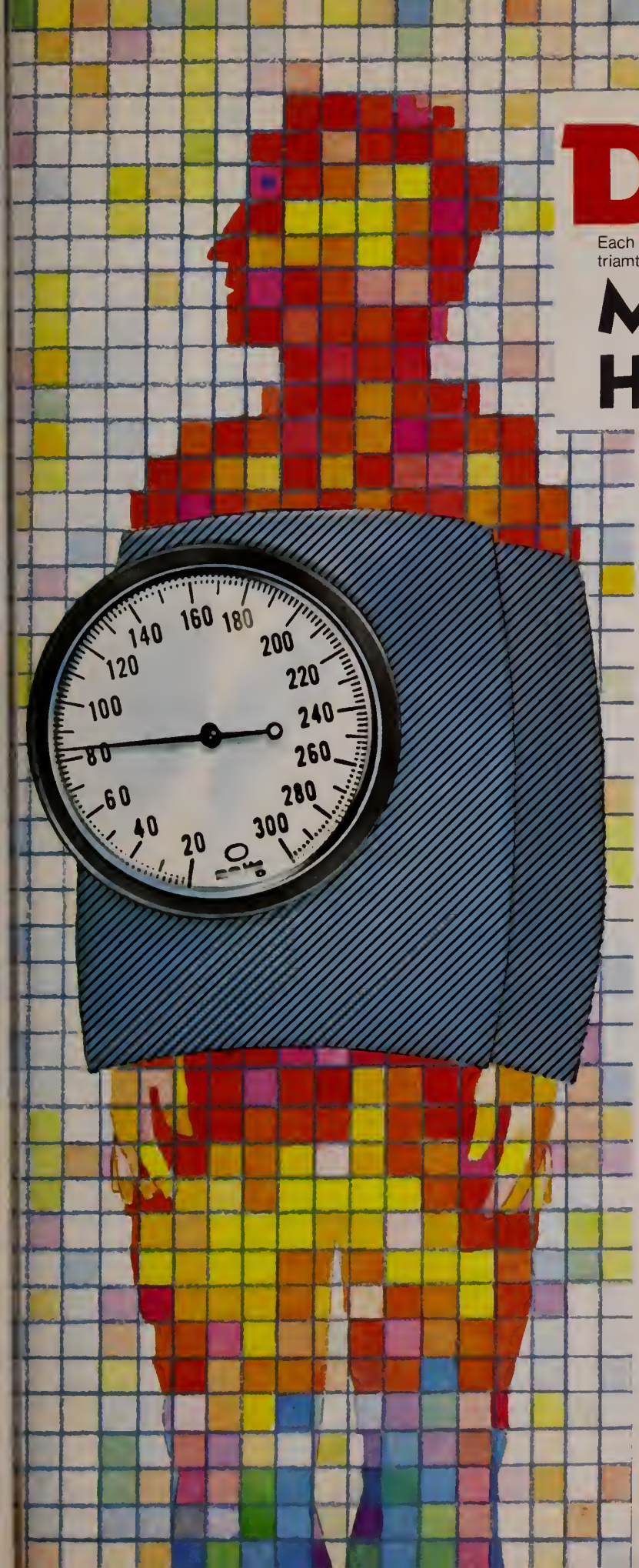
**MACOMB:** GP-FP 12 month contract practice—University Health Service. Outpatient clinic—no OB, Surgery. Fringes include hospitalization, paid vacation, retirement, etc. Approximately 13,000 students, city 23,000. Competitive negotiable income. Equal opportunity affirmative action employer. Contact: C. E. Hughes, M.D., Director BEU Health Center, WIU, Macomb 61455. (1)

**MATTOON:** American trained family practitioner or internist for rewarding practice. Fully equipped office available—new 210 bed hospital (open staff)—financial startup assistance—University of Illinois, Urbana Medical Campus, 40 miles. Mattoon is a prosperous, growing community of 25,000 with a patient population of 75,000. Contact: A. Rauwolf, M.D., 1120 Wabash, Mattoon 61938. (217) 234-6253. (4)

**PAXTON:** Paxton Community Hospital is enlarging its medical staff due to expansion of the facility and has openings for Family Practitioners to locate in the community. A 30 bed, general short term acute hospital offers full services to the community except for OB. The hospital, in East Central Illinois, is approximately two hours from Chicago, St. Louis, and Indianapolis, and 30 minutes from University of Illinois. The hospital is fully accredited by the JCAH. Contact Mr. David Polge, Administrator, Paxton Community Hospital, 651 East Pells, Paxton 60957. Phone 217-379-2387. (12)

**PEORIA:** Economical sound central Illinois community of 250,000 situated in picturesque river valley has need for family physicians and general internists to practice in a 300 bed community hospital affiliated with the University of Illinois, College of Medicine. Office space and financial assistance available. "A GOOD PLACE TO PRACTICE GOOD MEDICINE." Contact: John A. Smith, Administrator, Proctor Community Hospital, 5409 N. Knoxville, Peoria 61614. (309-691-4702) (3)

**WEST FRANKFORT:** Population 10,000, county 42,000. Coal mining growth area (1,200 new jobs). Offices available near hospital. On I57/24 in Southern Illinois. Major university near. Good highways, and recreation. Need OB-GYN, IM-CV, IM-GP and FP. Financial assistance. Contact: Wm. D. Palmer, Administrator, UMWA Union Hospital, 507 W. St. Louis St., West Frankfort 62896. (618-932-2155) (1)




# Dyazide®

Each capsule contains 50 mg. of Dyrenium® (brand of triamterene) and 25 mg. of hydrochlorothiazide.

# Makes Sense in Hypertension*

**Before prescribing, see complete prescribing information in SK&F Co. literature or *PDR*. A brief summary follows:**

* **Warning**
This drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual. If this combination represents the dosage so determined, its use may be more convenient in patient management. Treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

**Contraindications:** Further use in anuria, progressive renal or hepatic dysfunction, hyperkalemia. Pre-existing elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs.

**Warnings: Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired.** If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in the severely ill, with urine volume less than one liter/day, the elderly and diabetics with suspected or confirmed renal insufficiency. Periodically, serum K+ levels should be determined. If hyperkalemia develops, substitute a thiazide alone, restrict K+ intake. **Associated widened QRS complex or arrhythmia requires prompt additional therapy.** Thiazides cross the placental barrier and appear in cord blood. Use in pregnancy requires weighing anticipated benefits against possible hazards, including fetal or neonatal jaundice, thrombocytopenia, other adverse reactions seen in adults. Thiazides appear and triamterene may appear in breast milk. If their use is essential, the patient should stop nursing. Adequate information on use in children is not available.

**Precautions:** Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Watch for signs of impending coma in severe liver disease. If spironolactone is used concomitantly, determine serum K+ frequently; both can cause K+ retention and elevated serum K+. Two deaths have been reported with such concomitant therapy (in one, recommended dosage was exceeded, in the other serum electrolytes were not properly monitored). Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with thiazides. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effect may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine.

**Adverse Reactions:** Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances. Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and, rarely, allergic pneumonitis have occurred with thiazides alone.

**Supplied:** Bottles of 100 and 1000 capsules; Single Unit Packages of 100 (intended for institutional use only).

SK&F CO.
a SmithKline company
Carolina, P.R. 00630

# IMPAC

**ILLINOIS MEDICAL POLITICAL ACTION COMMITTEE**
55 East Monroe Street
Chicago, Illinois 60603
312/782-1963

NONPARTISAN

Dear Colleague

Now that the rhetoric has stopped and the election votes tabulated, I thought you might be interested in how your medical political action committee fared at the polls.

Overall, IMPAC's 1978 election results were impressive -- we participated in 238 contests and 218 IMPAC supported candidates were successful in their efforts to be elected to office, for a winning percentage of 91.5%. In the Illinois General Assembly, IMPAC supported 211 candidates, of which 197 were successful (93.3%) IMPAC supported 19 congressional candidates, 16 of whom won for a success ratio of 84.2%. And in the statewide races, IMPAC supported 8 candidates, 5 of whom were successful for a 62.5% winning percentage.

I find those statistics encouraging. They mean that in 238 separate cases, Illinois physicians were involved in political activity enough to ask your state medical political action committee for its support. Not all were successful -- but at least you made the effort.

At the same time, I find these statistics discouraging. IMPAC lost 20 contests, and I can't help wondering if a little more effort might have made the difference in some of those "too close to call" races. There were some surprises in this election -- some candidates which we supported even though we didn't think they could win were successful. Others which were considered "safe" lost. The end result -- a Republican governor, lieutenant governor, and U.S. Senator, a 13-11 Republican edge in the Illinois Delegation to the U.S. Congress, but a Democratic controlled Illinois State Senate and Illinois House of Representatives.

You will soon be receiving your 1979 dues billing and IMPAC membership solicitation. Please remember these important statistics and add your contribution to IMPAC when you write out the check for 1979 dues.

Sincerely,

Herbert Sohn, M.D.

Herbert Sohn, M.D.
Chairman

Contributions are not limited to the suggested amount. Neither the Illinois State Medical Society nor the AMA will favor or disadvantage anyone based upon the amounts of or failure to make pac contributions. Copies of IMPAC & AMPAC reports are filed with and are available for purchase from the Federal Election Commission, Washington,D.C. Contributions are subject to the limitations of FEC regulations, Sections 110.1, 110.2 & 110.5. (Federal regulations require this notice.) IMPAC reports are also filed with the State Board of Elections, and are or will be available for purchase from the State Board of Elections, 1020 South Spring Street, Springfield, Illinois 62704.

# Doctor's News

**DISASTER DRILL A SUCCESS**—A simulated explosion in north Chicago's Horner Park provided the background for this year's successful rehearsal in disaster preparedness recently. The Chicago Northside Commission on Health Planning, Chicago Hospital Council, sixteen participant hospitals, medical, fire and police personnel successfully treated 135 "victims" in less than 45 minutes for "wounds" ranging from lacerations to multiple contusions.

**EXCHANGE TO PAY DIVIDEND**—The Illinois State Medical Inter-Insurance Exchange Board of Governors has declared a dividend to be paid to those current policyholders insured during the 1976-77 and 1977-78 policy years. The dividend, which will be paid after January 1, 1979, amounts to 5½% of premium paid during 1976-77 and 1% of premium paid during 1977-78. The total payment will amount to $2.1 million.

**FEBRUARY MEXICO TRAVEL PROGRAM**—Reservations are still available for the ISMS-sponsored IXTAPA (Mexico) Holiday travel program, February 14-21. Departures for the eight day Mexican Riviera tour may be scheduled from Chicago and St. Louis. Price: $629 per person, double. For further information, please contact ISMS headquarters (312-782-1654).

**INCREASE IN CME ACCREDITATION FEES**—In response to the relentless pressure of rising costs and inflation, CME accreditation fees have been increased—the first such raise since the initial fees were set in 1973. The following fees, adopted by the ICCME Board of Directors, and ISMS Board of Trustees, are effective as of January 1, 1979. Registration fee: $100 (Waived for ISMS component societies); accreditation survey fee for medical organizations of 49 or fewer members: $300; all other CME sponsors: $450.

**HEALTH CARE ACHIEVEMENT AWARDS**—The Chicago-based Blue Cross and Blue Shield Plan recently announced the recipients of awards for private health sector progress in cost containment, quality and accessibility. Those honored were: Illinois Masonic Medical Center, Chicago; St. Francis Xavier Cabrini Hospital, Chicago; Perry Memorial Hospital, Princeton; George T. Mitchell, M.D., Marshall and Eugene P. Johnson, M.D., Casey; the Abraham Lincoln Health Maintenance Organization, Lincoln; Occupational Health Services, Rockford; United States Steel Corp. South Works; the River Bend Ambulance Association; and the Illinois Health Improvement Association. The awards were presented at a symposium, "Private Initiatives in Health Care," sponsored by Blue Cross/Blue Shield, and winners were selected by a committee comprised of representatives from the Chicago Hospital Council, Illinois Hospital Association, Chicago Medical Society, Illinois Clinic Managers Association, and ISMS. Watch the *Journal* for further details on innovations and projects which brought these awards.

**MENTAL HEALTH AND THE LAW**—An intradisciplinary organization to facilitate communication among lawyers, social workers, psychologists, psychiatrists, nurses and other professionals concerned with the interface of mental health and law has invited ISMS members to join or participate in their effort. The Illinois Academy of Mental Health and Law plans to sponsor programs and other activities in that area. Interested persons may contact Ronald Shlensky, M.D., Suite 1028, 251 E. Chicago Avenue, Chicago 60611.

**NEONATAL DEATH**—Findings reported recently to the Statewide Health Coordinating Council Ad Hoc Committee on Infant Mortality have indicated that the city of Chicago has the second-highest neonatal death rate among the five largest cities in the U.S. In discussing the problem, SHCC Chairperson Julia Cihak noted that 70% of all infant deaths in Illinois occur before infants reach one month of age. The Ad Hoc Committee has made the following recommendations: strengthened regional perinatal care programs through expanded follow-up care after discharge from intensive perinatal centers; greater professional and public education; extended prenatal care to high risk groups, and a vigorous attack on the causes of infant mortality. Persons interested in contributing to the Ad Hoc Committee's research are invited to write Charles Bennett, Statewide Health Coordinating Council, 525 W. Jefferson, Springfield 62761.

**NEW JOURNAL ANNOUNCED**—The Loyola University Medical Center recently initiated a quarterly publication, *Spina Bifida Therapy, An International Journal.* The Journal will deal solely with treatment and care of spina bifida from an intradisciplinary viewpoint. Those interested in subscribing should contact the Spinal Bifida Service at Loyola, 2160 S. First Avenue, Maywood, 60153.

**SICKLE CELL PROGRESS**—Research by a geneticist at the UI Medical Center in Chicago has brought a clue to a method for controling sickle cell anemia. Joseph De Simone, Ph.D., recently reported that research in animals has indicated a possible link between the level of fetal hemoglobin and the sickling process. Preliminary research has found that persons with a hereditary tendency to maintain high levels of fetal hemoglobin—which normally accounts for less than one percent of human blood after the first year of life—may carry sickle cell disease but show no symptoms. Research is directed at methods to increase and maintain the level of fetal hemoglobin in the blood of susceptible persons.

**PHYSICIANS IN THE NEWS**—**David A. Hilding, M.D.,** Winnetka, a professor of otorhinolaryngology at the UI Abraham Lincoln School of Medicine in Chicago, has been appointed medical director of the National Hearing Association. . . . **James A. Campbell, M.D.,** president and chief executive officer of Rush-Presbyterian-St. Luke's Medical Center, has been elected president of Alpha Omega Alpha, the national medical honor society. . . . The University of Health Sciences/Chicago Medical School has elected **Joseph M. White, M.D.,** to serve as president. Doctor White, chairman-elect of the national coordinating council on medical education, is currently provost for health affairs at the University of Missouri-Columbia.

**Harold N. Walgren,** Hinsdale, has been elected president of the Civil Aviation Medical Association. . . . Saint Mary of Nazareth Hospital has elected new officers for 1979. They are Doctors **Donald C. Wharton,** president, **Walter J. Kawula,** Lake Forest, president-elect, **Nelson D. Sanchez,** Western Springs, secretary, **Bruno Valadka,** Elmwood Park, treasurer and **Orest Jachtorowycz,** Chicago, general staff representative.

The American College of Chest physicians conferred the status of Fellowship to ten Illinois physicians at their recent meeting. Those honored were: **Antonio Q. Chan,** Oak Brook, **Anwar S. Choudhyr,** Westmont, **Rosemary M. DeLeon,** Lombard, **Iraj Delfani,** Wilmette, **Lanie E. Eagleton,** Springfield, **David L. Fishman,** Evanston, **Vishnu D. Gaiha,** Evanston, **Hae C. Lee,** Palos Heights, **Ralph E. Otto,** Evanston and **Ivan L. Shapiro,** Carol Stream. . . . Abbott Laboratories recently presented **Jacob L. Marks, M.D.,** Homewood, with an engraved "Golden Hour Clock" to commemorate 50 years of outstanding service and dedication to medicine.

## *President's Page*



# SPEAK UP

Criticizing the medical profession and the health care system appears close to attaining the status of a "national pastime." The most devoted participants in this new game are those advocating national health insurance.

Senator Kennedy's hearings throughout the country on NHI have captured the news media's attention. Front page accounts of the system's deficiencies are reinforced by nightly TV newscasts. Focal points of the media coverage are the hand-picked witnesses Senator Kennedy presents at each session to detail financial ruin caused by health costs.

Considering the potential impact of this media coverage, it is easy to conclude that the public must, by now, have become hostile toward the profession and the health system. If that assessment is correct, there really is nothing we can do to regain public support and ward off government medicine.

Fortunately, my experience indicates that the public generally is satisfied with the health care system and is not anxiously awaiting the arrival of NHI. During my travels throughout the state, I have addressed civic groups and appeared on audience-participation radio programs. It was conforting to learn that the majority of people view our health care system as the finest in the world . . . and believe that its faults can be remedied without dismantling the entire system.

How long will that attitude prevail? Considering the widespread attention given to the negative aspects of health care, one can only conclude that the public's opinion gradually will change. That is inevitable unless we take the offensive.

Physicians are in an ideal position to mold public opinion. That faceless mass referred to as the "general public" is composed of our patients.

It's about time we speak up!

David S. Fox, M.D., President



# Illinois State Medical Inter-Insurance Exchange

## The physician-owned professional liability insurance program

- Occurrence Coverage
- Choice of Limits
- Quarterly Premium Payments
- Part-Time Coverage Available

A physician-oriented, reciprocal insurance program for ISMS members



*Administered by*

Illinois State Medical Insurance Services, Inc.

55 East Monroe Street, Chicago, Illinois 60603 • 312/[illegible]

# *Viewbox*

*(Continued from page 391)*

**CORRECT DIAGNOSIS:**
**4. SARCOIDOSIS**

The original chest radiographs suggest a fine milliary pattern of the lungs.

The gallium scan demonstrates prominent increased uptake in the pulmonary parenchyma as well as multiple areas of increased uptake over both hila.

The combination of these findings is suggestive of sarcoidosis of the lung.

Other entities that could produce a similar appearance in the correct clinical setting are:

1. Recent lymphangiography. However, it is not expected that lymphangiography would produce positive hilar nodes on gallium scan. The administration of ethiodol can produce an inflammatory reaction in the lung that will be positive on gallium scan.

2. Interstitial pneumonitis. Interstitial pneumonitis could produce patchy areas of increased uptake in the lung, but would likely not produce areas of this uniformity of uptake nor would the hilar nodes be as prominently identified.

3. Pneumoconioses have been reported to concentrate galliam as well.

4. Idiopathic pulmonary fibrosis can also have a positive gallium scan and gallium is useful in monitoring the progress of the disease.

5. Bleomycin toxicity will also produce diffuse gallium uptake in the lung. This is a reversable phenomenon and disappears after cessation of therapy.

6. Common inflammatory diseases including tuberculosis and pyogenic pneumonias will also show increased gallium uptake in a focal fashion.

The pattern of diffuse pulmonary uptake with prominent hilar uptake is most suggestive of sarcoidosis. Indeed, in this patient, there is biopsy evidence of sarcoidosis.

Normal accumulation of gallium in the lungs does not occur. The presence of intense lung uptake or focal lung uptake should be thoroughly evaluated. In patients with known lymphomas, a history should be obtained concerning recent lymphangiography. In the absence of recent lymphangiography, pleural or parenchymal involvement in the lung by the lymphomonous process should be considered.

**References**

1. Heshiki, A., Schatz, S. L., McKusick, K. A., *et al.*, "Gallium-67 Scanning In Patients With Pulmonary Sarcoidosis," *Am. J. Roentg., Rad. Ther. and Nuc. Med.*, 122:744, 1974.
2. Hoffer, P. B., Bekerman, C., Henkin, R. E.: Gallium-67 Imaging, John Wiley & Sons, New York, 1978.

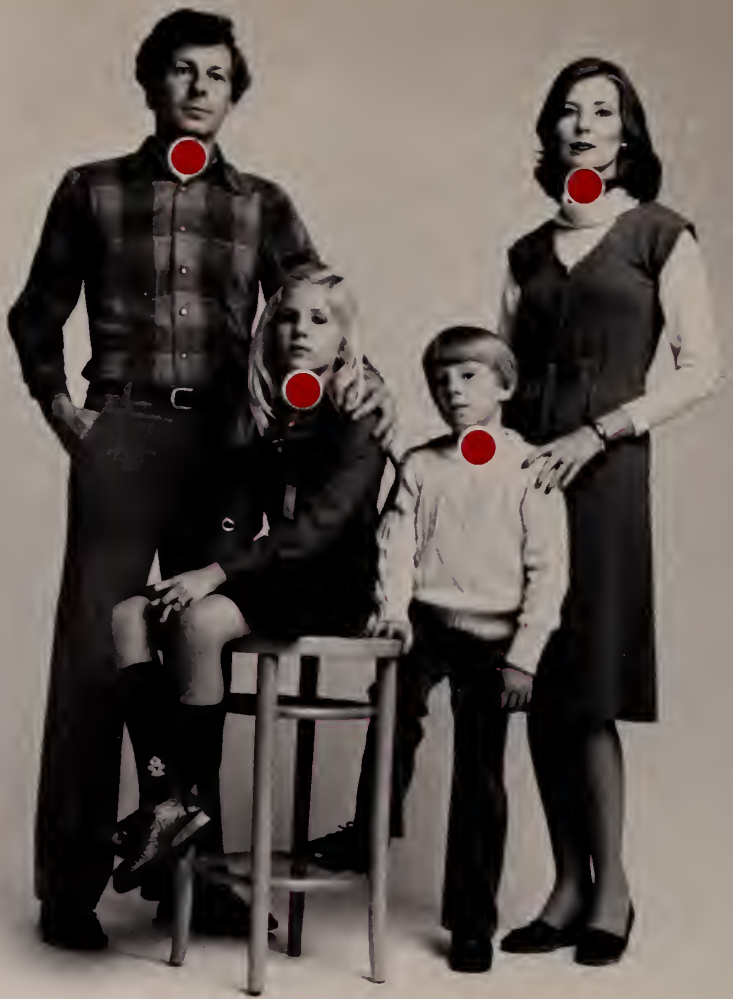
# *EKG*

*(Continued from page 399)*

**Answers: 1. E. 2. D.**

The top line shows a normal ST segment response to exercise at a heart rate of 150 beats per minute. Beats 14 and 15 are a couplet or pair of premature ventricular beats. Beat 16 is a sinus beat followed by another premature ventricular beat and a subsequent run of ventricular flutter at a rate of more than 300 beats per minute. In the middle rhythm strip, the ventricular flutter is deteriorating to ventricular fibrillation when a 400 watt-second direct current countershock is applied to the patient. The bumps in the second half of the middle strip as well as the bottom strip are the result of cardiopulmonary resuscitation (CPR). In the middle of the bottom strip, sinus bradycardia at a rate of 46 beats per minute can be seen when CPR is momentarily stopped. Subsequently, one milligram of Atropine was given and the patient was transferred to the Coronary Care Unit. No myocardial infarction was demonstrated by enzymes or ECG changes. The patient was discharged seven days later with a greater understanding of the importance of his medications.

This experience points to the fact that the bypass surgery does not eliminate foci of ventricular irritability although they may be more easily controlled with drugs post-operatively. It also confirms the low incidence of death on the treadmill despite the fact that patients with serious cardiac disease may be submaximally stressed. Malignant cardiac arrhythmias are promptly controlled because equipments, drugs, and staff trained in CPR are available in the exercise lab. Although large numbers of patients taking Procainamide must discontinue it because of toxicity, our patient simply reduced his dose gradually because he did not like taking medicine. For further reading in these areas, see B. D. Kosowsky, *et al., Circulation* 47:1204, 1973 on Procainamide and I. F. Tabry, *et al., Circulation* 58:I-166, 1978, Cardiovascular Surgery Supplement, on the effect of surgery on ventricular tachyarrhythmias.



# Is it strep?
# Isocult® answers on the spot.

The 'Isocult' in-office culture test for throat streptococci identifies beta strep in 24 to 48 hours, so you can start treatment promptly.

In addition it indicates the possibility that antibiotic therapy should be continued for 10 days. Alerts you to the need to culture specimens from other family members. And provides a basis for follow-up culture in 14 days to test for cure.

**Simple. Reliable. And efficient.** The 'Isocult' exclusive Selec-strep® culture medium inhibits growth of most non-streptococcal throat organisms. Office personnel can read results easily by simple color-comparison with the 'Isocult' Organism Identification Chart.

And you can cover the cost of professional time while providing your patients with a savings over standard laboratory culture fees.

**Is it bacteriuria? 'Isocult' answers on the spot.** The 'Isocult' culture test for bacteriuria (like the 8 other in-office 'Isocult' tests) is reliable, rapid, inexpensive and easy to interpret (results are available within 18-24 hours). All tests are conveniently packaged for office storage. And competitively priced.

**For more information, or to order, call toll free: (800) 538-1581.**
(In California, call the number below, collect.)

*'Isocult' is available through local distributors, nationwide.*

SKD
a SmithKline company

**SmithKline Diagnostics**
880 West Maude Avenue, P.O. Box 1947, Sunnyvale, CA 94086 • (408) 732-6000

# CLASSIFIED ADVERTISING

## POSITIONS & PRACTICE OPPORTUNITIES

**FULL TIME PHYSICIAN** for Industrial Clinic in Skokie. Surgical experience needed. Salary negotiable. Must have Illinois license. Call (312) 674-4800, Mrs. McCubbin.

**OPPORTUNITIES FOR PHYSICIANS IN INDIANA**—There are several excellent openings among the Indiana State Hospitals at various locations throughout the state for psychiatrists and physicians of other specialties, at most experience levels. A newly-revised salary schedule offers a very competitive income plus a generous package of fringe benefits. An adjunct practice is possible beyond the regular working hours and on-call responsibilities. Please reply with a copy of the c.v. to: Farabee & Associates, Inc., P.O. 8ox 472, Murray, KY 42071 or call (collect) (502) 753-9772. Farabee is retained by the Indiana Department of Mental Health.

**EMERGENCY DEPARTMENT PHYSICIAN:** Become part of an expanding, dynamic multispecialty clinic in midwest university community of 100,000. Excellent salary, benefits. Write or call Medical Director, Carle Clinic, Urbana, IL 61801, (217) 337-3239.

**FAMILY PRACTITIONER**—To associate with one senior general practitioner and one surgeon in rural southern Illinois. Excellent educational system and recreation. Financially sound community. One hour from St. Louis. JCAH 72-bed hospital in Nashville. Association available now. Contact: T. K. Janssen, Administrator, Washington County Hospital, Nashville, Illinois, (618) 327-8236.

**ILLINOIS—PEORIA**—Interviewing career Emergency Physicians for full-time openings starting immediately and Jan. 1. Opportunity to join young ACEP oriented physicians' group in 550-bed Medical-Surgical Hospital affiliated with Peoria School of Medicine. Good specialty backup. Flexible scheduling. Superior compensation with liberal fringe benefits including malpractice. Contact H. T. Stratton, M.D.; Methodist Medical Center, 221 NE Monroe, Peoria, IL 61636; (309) 672-4974 or (309) 672-5501.

**PHYSICIAN WANTED.** Full or part time for fully equipped medical center. Large welfare practice. 2B23 N. Clybourn, Chicago, Ill. 60618. Telephone—(312) 929-6999 or 664-3157.

**OCCUPATIONAL MEDICINE**—National corporation needs associate medical director in Skokie, Illinois; occupational medical experience desirable. Corporation dedicated to comprehensive health program for all employees; modern well equipped facilities; liberal fringe benefits include life and health insurance, excellent savings plan, malpractice insurance coverage, liberal vacation, holiday and sick leave policies, etc.; salary commensurate with position responsibilities, experience and professional training. Send resume in confidence to 8ox 935, c/o Illinois Medical Journal. An Equal Opportunity Employer.

**PHYSICIAN WANTED:** General medical services to be provided to psychiatric patients. Full and part-time positions available. Generous fringe benefits. Salary negotiable. 50 minutes from downtown Chicago. Contact Claude Roush, Superintendent, Manteno Mental Health Center, Manteno, Illinois 60950. (815) 468-3451.

**LOCUM TENENS—EMERGENCY MEDICINE**—available in our 100 hospitals; monthly scheduling is flexible and according to your preferences; malpractice is paid, excellent hourly income according to your flexibility and hours worked. Call toll free 1-800-325-3982, ext. 220 for details.

**OPPORTUNITY IN FAMILY PRACTICE**—Two Board Certified Family Physicians need third physician. New office connected to new hospital (250 beds) with all ancillary and specialized services available. Any interested physicians please snd curriculum vitae to Link, Chapman & Associates, Inc., 1515 West Truman Road, Independence, Missouri 64050, or call collect 816-836-8200; 9:00 a.m. to 4:30 p.m.

**IN PATIENT CLINIC PRACTICE** at Illinois Developmental Centers; various locations. Monday through Friday, days only, no night or weekend call. Guaranteed income of $40,000-$50,000. Send CV to T. P. Cooper, M.D., 970 Executive Parkway, St. Louis, MO 63141, or call toll free 1-800-325-3982.

**ORTHOPEDIC SURGEON** who desires to locate in a rural area of southern Illinois needed to serve two community hospitals. One hour from St. Louis. Good educational system for children. Excellent recreation. Reply: T. K. Janssen, Administrator, Washington County Hospital, Nashville, Illinois 62263.

**A PROGRESSIVE RURAL COMMUNITY** in midwestern Indiana desires to secure two or more general practitioners. Interested parties would find new schools, a new nursing home, new banks, good hospitals nearby, etc. A medical center with purchase option will be built to accommodate these physicians. Contact J. D. Piech, 1600 E. Liberty, Covington, Indiana. (317) 793-4818.

**ILLINOIS DEVELOPMENTAL CENTERS:** Background in primary care and psychiatry helpful; Interdisciplinary team approach. Monday-Friday, days only, nights or weekends optional; excellent remuneration; Illinois license required. Contact T. P. Cooper, M.D., 970 Executive Parkway, St. Louis, MO 63141 or call toll free 1-B00-325-3982, ext. 213.

**FAMILY PRACTICE SPECIALIST NEEDED** in busy expanding, future oriented, multispecialty clinic to participate in development of new department; three department members plan curriculum for AAFP approved family practice residency; ample opportunity for developing, fulfilling, primary practice and personal development; located in university community; liberal financial and fringe benefits. Contact: Medical Director, Carle Clinic, Urbana, IL 61801. (217) 337-3239.

**MATTOON-CHARLESTON, ILLINOIS**—Sara Bush Lincoln Health Center Emergency Department has openings for qualified physician; guarantee $50,000-$55,000 with ideal working conditions and schedule. Send curriculum vitae to Stephen Allin, M.D., Emergency Department Director, P.O. Box 372, Mattoon, Illinois 61938 or call toll free 1-B00-325-39B2 for details.

**EMERGENCY PHYSICIAN—WOOD RIVER, ILLINOIS,** St. Louis area hospital treating 15,000 patients annually. Excellent nursing staff, modern facility. Flexible scheduling, 2/24 hour shifts a week. Remuneration from $47,000. Paid malpractice insurance. Send curriculum vitae to Judy Patterson, M.D., Director of EMS, Wood River, IL 63136 or call toll free 1-800-325-3982.

**PRACTICE AVAILABLE**—Retirement dictates sale of most profitable obesity control practice located in Rockford, Illinois, approximately 4,000 patients with an unlimited growth potential. Contact: Mrs. Curt Steffen at (B15) 965-59B3.

**OPENING FOR** Board Certified Cardiologists, Internists, Pediatricians, Rheumatologist, OB/GYNs, Ophthalmologists, Emergency Room Physicians, Orthopedic Surgeons, and Family Practitioners in Dallas, Austin and numerous cities in Texas. Also need two Family Practitioners and Orthopedic Surgeon in Chicago. Must have Flex or Illinois license. Group and solo practices available. NO FEE. Send C.V. or call Wellington Smith, Texas Doctors Group, Box 177, Austin, Texas 78767. (512) 476-7129.

**STAFF PHYSICIAN WANTED**—The Johnston R. Bowman Health Center tor the Elderly at Rush Presbyterian-St. Luke's Medical Center is seeking a 8oard Certified internist to serve as a full time staff physician caring for acute and rehabilitative patients at our unique health care facility. Salary negotiable with private practice opportunities available. Please contact Rhoda S. Pomerantz, M.D., Medical Director, at (312) 942-7021.

**PHYSICIAN NEEDED** for full and part time. Family practice in inner city. For further information, contact Judy Brown (312) 751-4000.

**THREE YEAR APPROVED PSYCHIATRIC RESIDENCY** Program now appointing for an immediate unexpected opening for July, 1979. Small intensive psychiatric hospital, JCAH approved, affiliated with Univ. of Iowa Medical College. Comprehensive program including two adult psychiatric units, adolescent unit, children's unit, alcohol & drug abuse unit, with innovative community liaison, and OPD. Eclectric approach. Situated in picturesque NE Iowa near large cities with cultural advantages, but in rural setting. Ideal for family living. No financial sacrifice while learning. Top salary: first year $23,478, second year $24,648, third year $25,896; liberal fringe benefits; some housing available. Opportunity to join staff upon completion of training. All applicants must have completed one year in an American approved training program in internal medicine, family practice, or pediatrics or a flexible one year program, including four months in internal medicine. Write or call J. T. May, M.D., Superintendent, or B. J. Dave, M.D., Director of Education, Mental Health Institute, Independence, Iowa 50644.

**FAMILY PRACTITIONER—NEEDED IMMEDIATELY** to join present three doctor family practice group that is incorporated; practice is equally divided between office and hospital; location is northwest suburb of metropolitan Chicago; beginning salary is $40,000 to $45,000 the first year based on qualifications; full partnership available with an opportunity to invest in the clinical building; there will be equal sharing of night call and weekend call among the group from the beginning of the association; this is an excellent opportunity for a family practitioner who is Board certified or qualified. Contact Clinical Assoc., S.C. c/o Dr. George L. Lagorio, 484 Lee Street, Des Plaines, Ill. 60016. Telephone AC 312-827-3101.

**FAMILY PRACTICE OPPORTUNITY**—Central Washington State, need M.D. interested in general family practice with 4 day week. Have 3 P.A.'s on board for all night and weekend work. Considerable general practice, peds, OB and surgery; willing to provide additional training in surgery and obstetrics. Above average salary, negotiable. Housing available. Very well equipped hospital. Need additional help due to partner retiring. Mostly young family area, population 12,000, moderate growth expected. Call collect day or night: Richard P. Bunch, M.D., 361 E. Main, Othello, Wa. 99344. Office: (509) 48B-3282, (509) 488-9252, Home: (509) 488-5044.

**ACCREDITED FIVE-YEAR GENERAL SURGERY RESIDENCY** program at Illinois Central Community Hospital, 5800 Stony Island Avenue, Chicago, Illinois, (312) 643-9200. Positions available in July, 1979, are PGY1 and PGY2 levels. Contact: Dr. William Lawrence, Chief of Surgery.

**EMS CONCEPT** now being developed in Orlando, Florida by Medical Emergency Service Associates (MESA), S.C. Now hiring only the most qualified physicians to staff emergency department. High pay, excellent working conditions, flexible scheduling and fringe benefits available to qualified physicians for work in Orlando emergency departments. Send all CVs to: M.E.S.A., 188 Industrial Drive, Suite 316, Elmhurst, Illinois 60126.

## FOR SALE, LEASE OR RENT

**MEDICAL OFFICE SUITE FOR RENT,** Lincoln-Belmont Bldg. 715-1200 square feet, available at once in full service, elevator, active professional building. Call Gary Solomon, (312) 334-5400.

**SUITE TO LEASE** for Internist, Pediatrician, Psychologist, Psychiatrist or other medical practice. Suite is located in a high quality building with a growing medical community situated across from a major hospital. The complex already includes an outstanding lab, X-ray facility, pharmacy and 16 professionals. Arrangement provides flexibility for the new tenant to share a suite with an existing practice, to have office built in newly created bare space and to participate in the ownership and direction of the complex. STRONG Property Managers, Ltd. Agents, 201 W. Springfield, Champaign, IL 61820. (217) 356-2617.

**LISLE-MEDICAL SUITE** available in prestigious modern building located on Rt. 53 in Lisle. X-ray facilities on premises. Zone controlled heating and air conditioning. Ample parking. Call 969-2850.

**INGALLS MEMORIAL HOSPITAL**—New professional building, Harvey, Ill. Suites to doctors specifications. Housekeeping, maintenance, utilities included. Ample patient parking. Enclosed walkway to hospital. McKey & Poague Agents. (312) 331-4226.

**SUB-LEASE** active general practice of 30 years in northwest suburb of Chicago. Five rooms fully equipped—excellent location in medical building with pharmacy—furniture, instruments, and records. Immediate possession. Call (312) 697-4372.

**FOR THE INDIVIDUAL OR GROUP** desiring the ultimate piece of residential property in the western suburban area. Eleven plus acre estate in Naperville with nine hundred plus foot frontage on the Du Page River. Estate landscaped and covered with hundreds of beautiful, mature oak and blue spruce trees. Price $680,000. Shown by appointment. 355-8998.

**RANCH-STYLE MODERN MEDICAL-DENTAL BUILDING FOR RENT** or sale: Customized facilities to meet every medical and dental need. Ideal for family physician or group practice. 1500 to 2500 sq. ft. available. Armitage and Damen area, Chicago. Near St. Mary of Nazarene Hospital. Excellent location for neighborhood practice. (312) 743-2371 or 338-9347.

**SALE OR LEASE**—Eye or ear nose throat, or both—retiring—mod. one story brick bldg.—9 rms., 3 lavs., carpeted—wood panelled—central A.C.—practice—office—equipment—surgical instruments—gas ht.—ample parking—only e-ent man in town—on Main Street—11 hospitals—38 years practice—will introduce—will negotiate. Call or write E. J. Sodaro, M.D., 7620 Madison Street, Forest Park, Illinois 60130. Phone: 312-366-1950.

**RUSSIAN TREASURES**—private—Antique jewelry, silver enamel and miniature boxes and tableware, icons, brass SAMOVAR, unique oil paintings and more. (312) 561-4312.

**ILLINOIS CENTER FOR PSYCHOTHERAPY** at 5225 Old Orchard Road in Skokie, IL. has large modern office space to sublet—furnished, all utilities, parking—ideal for psychiatrist or psychologist—rent negotiable—available immediately. (312) 966-9610.

**NINE HUNDRED PLUS FEET** of office space for rent in modern professional building—near schools. Excellent opportunity for establishing a practice in Geneva, Ill. Cates & Sacrey Building, 328 Anderson Blvd., Geneva, Ill. 60134.

## SITUATIONS WANTED

**31 YEAR OLD MALE** 2 years post graduate training. Four years of emergency practice. High volume and high trauma in the four years. BLS provider BLS instructor ACLS provider seeking fee for service with partnership. C.V. on request. Available now. P.O. Box 425, Western Springs, IL 60558.

**31 YEAR OLD MALE** 2 years post graduate training 4 years of emergency practice. BLS, ACLS provider. BLS instructor ER experience in high volume and high trauma in the four years. Member AMA, ACEP. Seeking ER directorship. CV on request. P.O. Box 425, Western Springs, IL 60558.

**INTERNIST,** 29, FMG, seeks relocation. Available IMMEDIATELY. Write Box 936, c/o IMJ, 55 E. Monroe, Suite 3510, Chicago 60603.

**SERVICES RENDERED:** Professional typing from rough draft or dictation from cassettes or stenorette reel. Satisfaction guaranteed. 312/485-7650 or 352-5698. 8901 Southview, Brookfield, IL 60513.

## MISCELLANEOUS

**PECAN HALVES—WALNUTS—SLICED ALMONDS!** Three-quart sampler, $9.95 postpaid; Canecreek Farm, Box 2727-MJ, Cookeville, TN 38501.

## GUARANTY FUND CERTIFICATE

**GUARANTY FUND CERTIFICATE:** Wanted to purchase-Guaranty Fund Certificates for the Illinois State Medical Inter Insurance Exchange—call (312) 423-4499.

**GUARANTY FUND CERTIFICATE** for sale: Class 5, territory II for $1,000,000/$1,000,000 coverage, purchase price $6,024.00. For sale for $4,500.00. For information call (816) 364-5255, or write to Professional Anesthesia Services, Inc., 416 North Seventh, St. Joseph, MO 64501.

**I.S.M.S. GUARANTY FUND** ($6840.00) Certificate discounted for sale. Class 4, territory 1, number 7340, $1,000,000.00/$1,000,000.00. Sale price: $5130.00. Contact Sandra (312) 442-6500 Ex 233.

**GUARANTY FUND CERTIFICATE** for sale. Class 5, Territory 2. Purchase price $4,792.00. Available after Jan. 15, 1979. Best offer. C. J. Perini, M.D., R.R. #2, Freeport, Ill. 61032. Phone: (815) 235-7301 or 235-5111.

**ILLINOIS STATE MEDICAL INTER-INSURANCE EXCHANGE** Guaranty Fund Certificate for sale. Territory 1 Class 1. Purchase price $772. Best offer. Contact Dr. Moran at (312) 425-8000 Ext. 5566.

**GUARANTY FUND CERTIFICATE** for sale. Class II. 1 million/1 million coverage. At discount. Call (312) 484-5660.

**GUARANTY FUND CERTIFICATE:** Price (original) $6024.00, class 5 (now class 8), Plastic Surgery, territory II, 1,000,000/1,000,000 coverage. Have changed Insurance companies. Call J. Monasterio, M.D. 858-8396 or evenings at 858-8395.

**GUARANTY FUND CERTIFICATE** for sale, Class I, Territory II Original Price $724—Best offer. (217) 875-1277.

**$3060.00 GUARANTY FUND CERTIFICATE** for $2500.00. Number 2527. Retiring. Jack T. Haskins, M.D. (618) 234-6667 or 618-233-0972.

**GUARANTY FUND CERTIFICATE** in the face value of $1548 which will satisfy a Class II surplus requirement in the program. Best offer. Contact: Dr. George F. Dietz, (312) 346-1565.

**CLASS 5 TERRITORY 1 SURPLUS CERTIFICATE,** original price $7,224 will sell at 10% off. Richard L. Mon, M.D., 2938 Alexander Cr., Flossmoor, Illinois 60422. (312) 957-9268.

**GUARANTY FUND CERTIFICATE** for sale: Class 5, territory 1 for $100,000/$300,000 coverage, purchase price $5420. Best offer. Contact: Mrs. Wilcoxen—(309) 692-6687.

**CERTIFICATES TO SELL:** Moved to Indiana—want to sell. Class V ISMS Inter-Insurance Exchange Certificates—original price $10680—discount available. Call (219) 980-4543 or (219) 769-4333.

**GUARANTY FUND CERTIFICATE** Class I for sale. Original price $1,032.00. No reasonable offer refused. (814) 371-1029.

**GUARANTY FUND CERTIFICATE** Territory II Class II 1,000,000/1,000,000. Original cost $876.00. Contact Russell M. Jensen, M.D., 57584 Sierra Way, Yucca Valley, Calif. 92284. (714) 365-9161.

**GUARANTY FUND CERTIFICATE** for Sale—Face Value $4792.00. Will sell for $4000.00. Contact phone (309) 788-4772.

*IMJ and ISMS are not acting as brokers or agents; this is provided as a membership service.*

# Librium®
## chlordiazepoxide HCl/Roche



5mg, 10mg, 25mg capsules

- ☐ Proven antianxiety performance
- ☐ An unsurpassed safety record
- ☐ Predictable patient response
- ☐ Minimal effect on mental acuity at recommended doses
- ☐ Minimal interference with many primary medications, such as antacids, anticholinergics, diuretics, cardiac glycosides and antihypertensive agents

**Before prescribing, please consult complete product information, a summary of which follows:**

**Indications:** Relief of anxiety and tension occurring alone or accompanying various disease states. Efficacy beyond four months not established by systematic clinical studies. Periodic reassessment of therapy recommended.

**Contraindications:** Patients with known hypersensitivity to the drug.

**Warnings:** Warn patients that mental and/or physical abilities required for tasks such as driving or operating machinery may be impaired, as may be mental alertness in children, and that concomitant use with alcohol or CNS depressants may have an additive effect. Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported.

**Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

**Precautions:** In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

**Adverse Reactions:** Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

**Usual Daily Dosage:** Individualize for maximum beneficial effects. Oral—Adults: Mild and moderate anxiety and tension, 5 or 10 mg t.i.d. or q.i.d.; severe states, 20 or 25 mg t.i.d. or q.i.d. Geriatric patients: 5 mg b.i.d. to q.i.d. (See Precautions.)

**Supplied:** Librium® (chlordiazepoxide HCl) Capsules, 5 mg, 10 mg and 25 mg—bottles of 100 and 500; Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10; Prescription Paks of 50, available singly and in trays of 10. Libritabs® (chlordiazepoxide) Tablets, 5 mg, 10 mg and 25 mg—bottles of 100 and 500. With respect to clinical activity, capsules and tablets are indistinguishable.

# synonymous with relief of anxiety

ROCHE

Roche Products Inc.
Manati, Puerto Rico 00701

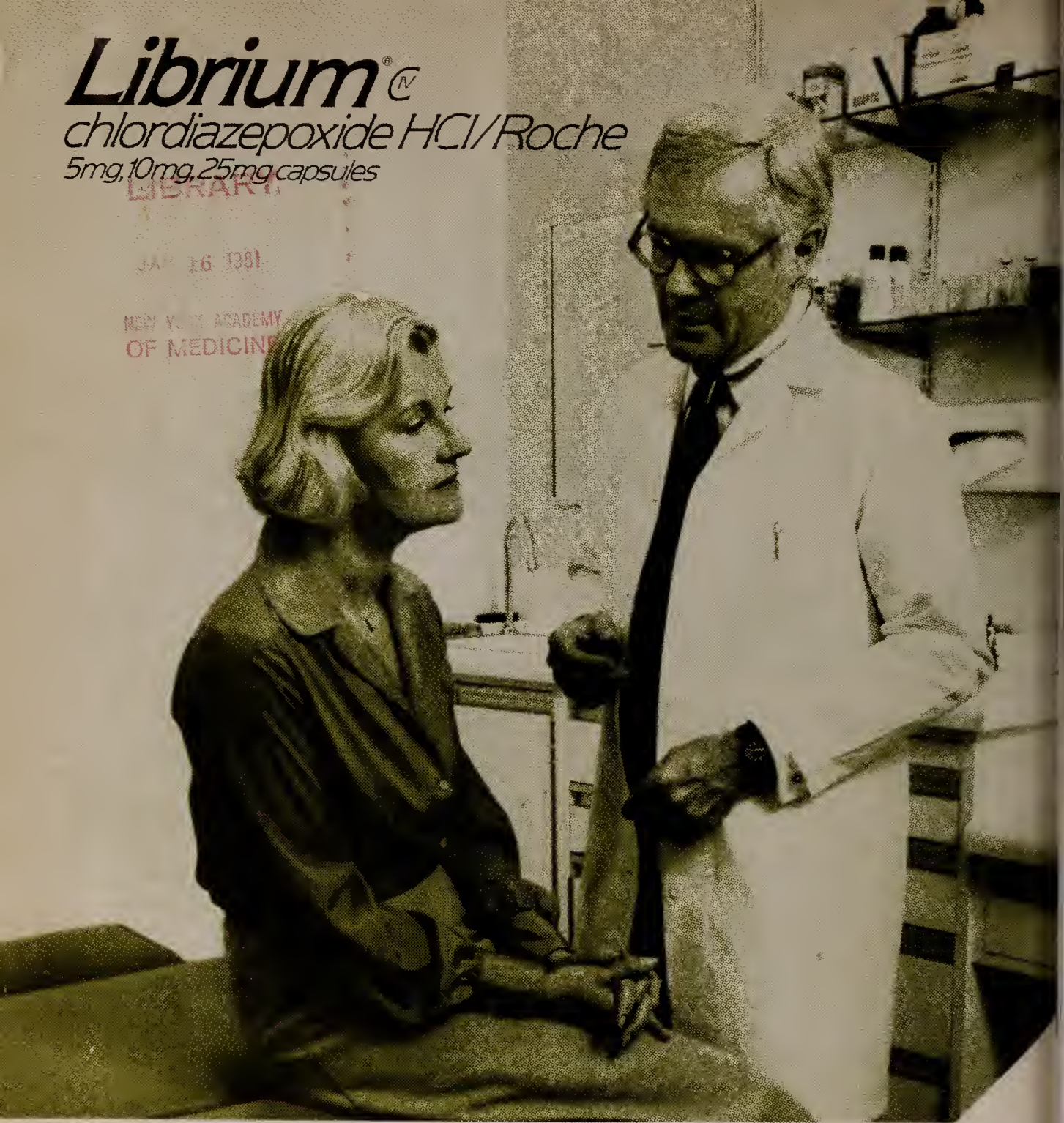
**Please see following page.**

# Librium® C.V.

## chlordiazepoxide HCl/Roche

5mg, 10mg, 25mg capsules

LIBRARY
JAN 16 1981
NEW YORK ACADEMY
OF MEDICINE



## synonymous with relief of anxiety

ROCHE

Please see preceding page for a summary of product information.

*The New York Academy of Medicine*

DUE IN 4 WEEKS UNLESS RENEWED
NOT RENEWABLE AFTER 8 WEEKS

| DATE BORROWED | BORROWER |
| --- | --- |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |

NEW YORK ACADEMY OF MEDICINE
3 0681 0207600 6